

043935 FEB

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8703180

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH ANN KNUDSEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>02 09 87</b>			2b. HOUR <b>2:51a M</b>			
3 SEX <b>FEMALE</b>		4 RACE <b>White</b> C		5. DATE OF BIRTH MONTH DAY YEAR <b>11 10 86</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>3 months</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC - 6701 N. CHARLES STREET</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>4230 Cardwell Ave 21236</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert John Knudsen</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Linda Jane Scheerer</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT ADDRESS <b>Balto, MD 21236</b> <b>Mrs. Linda J. Knudsen 4230 Cardwell Avenue</b>						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>SEPSIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRONCHOPNEUMONIA</b>	
		DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPOPLASTIC THORAX</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>Leslie L. Walters</i>		DEGREE		22c. DATE SIGNED <b>2/9/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LESLIE L. WALTERS, M.D.</b>		22e. ADDRESS <b>GBMC; 6701 N. CHARLES ST. BALTO., MD 21204</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb 10, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., MD.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Dippel Funeral Homes, Inc. 7110 Belair Road Baltimore, MD 21206</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1987</b>		25b. REGISTRAR'S SIGNATURE <i>John E. Anderson</i>	

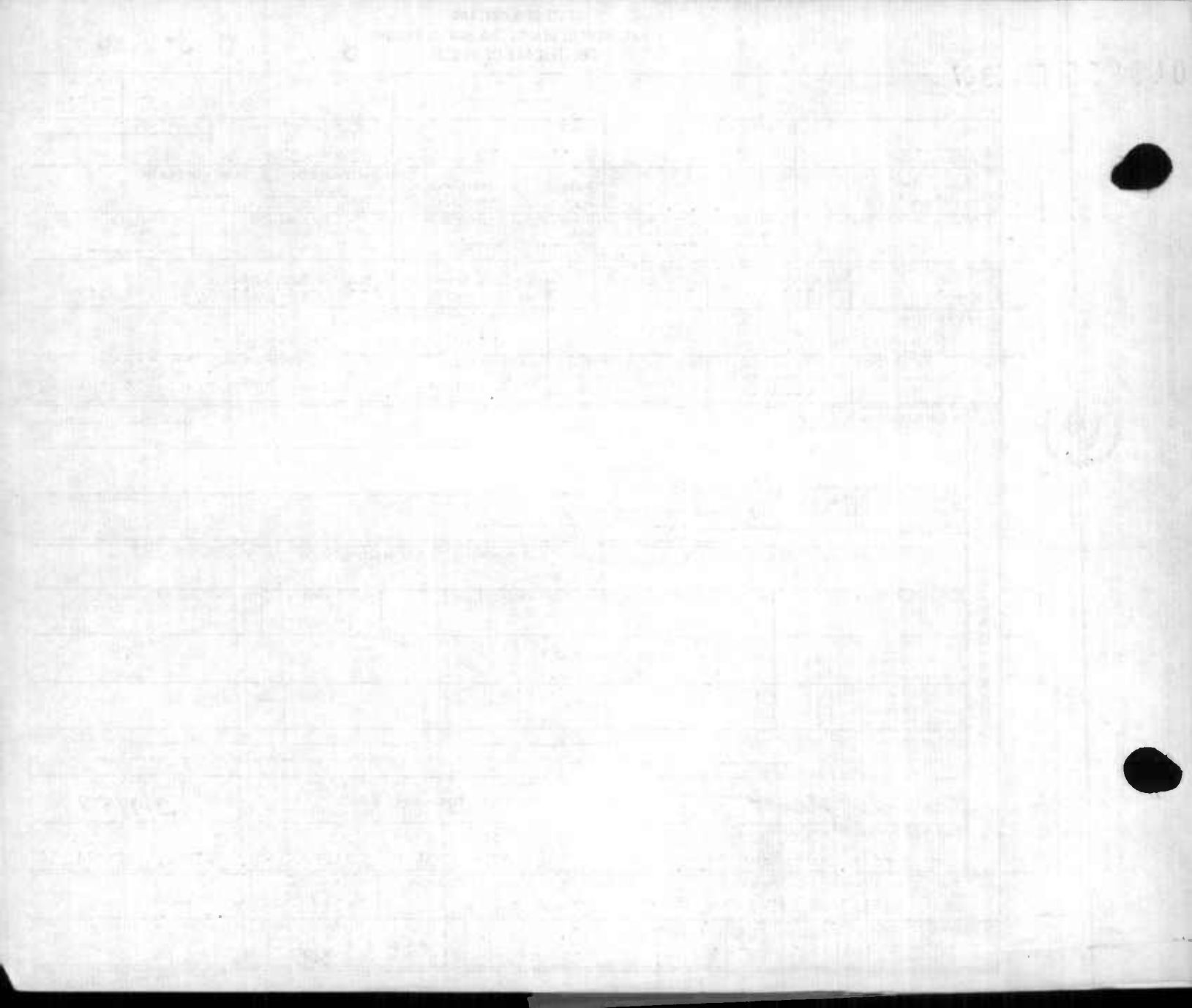
BP  
DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from pages 1 & 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION



044210

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03 / 81

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Louis George KONSTANT</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>02 14 87</b>		2b. HOUR <b>7 14 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 29, 1915</b>	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co. MD.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Konstant</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgia Contis</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW-II 212-14-8458</b>		17. INFORMANT <b>953 Beaverbank Circle Towson, Md. 21204</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Renal Impairment @ Pneumonia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>01. 19. 19 82</b> to <b>02. 14. 19 82</b> that (I) (we) lost saw the deceased alive on <b>02. 14. 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>02-14-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. R. N. R.</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 17, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Baltimore, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Eckhardt Funeral Chapel</b>		ADDRESS <b>Owings Mills, Md. 21117</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 17 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit permit. Then, remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, whether traumatic event, the medical examiner must be notified orally.

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Balladines



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

03782

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAMPROS NICHOLAS KONTOS			2a. DATE OF DEATH MONTH DAY YEAR February 20, 1987		2b. HOUR 3:45 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 6 17	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1509 Chapel Hill Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurateur	12b. KIND OF BUSINESS OR INDUSTRY Food	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1509 Chapel Hill Drive 21237	
14. FATHER'S NAME FIRST MIDDLE LAST Nicholas Lampros Kontos			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Kalafatis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	16c. SOCIAL SECURITY NO. 193-10-9757	17. INFORMANT ADDRESS Mrs. Valerie Sunderland, 2203 Kentucky Ave. Baltimore, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Laennec's Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>25 yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>2/13</u> , 19 <u>87</u> , to <u>2/8</u> , 19 <u>87</u> , that (if (we) last saw the deceased alive) <u>2/8</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>2/24/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. PARLOMENT</u>		22e. ADDRESS <u>9518-B Phila. Rd. Balt, Md 21237</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-23-87	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.
24. FUNERAL DIRECTOR OR NAME <u>Matthews, Matthews Funeral Home</u> <u>3021 Eastern Ave., Baltimore, Md. 21224</u>			25a. DATE REC'D. BY REGISTRAR <u>FEB 26 1987</u>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

045517

James O. Johnson

1972

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1934-1935

2018-01-04 14:00

5020 0 5 034

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
043577		FOR STATE REGISTRAR		Julia Helen Kowalski				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Julia		H.		Kowalski		2/8/87		2b. HOUR 4:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR MONTHS DAYS	
Female		white		5 15 02		84 yrs		YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Germany		USA				Baltimore County		Randallstown 21133	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. CITY OR TOWN	
Baltimore County General Hosp.		Dietitian		Hospital		MD		Essex	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Thomas Skowronski		Helen ?		No		212 09 1925		Charles J. Bobart Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Status post respiratory arrest.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 9, 1987</u> to <u>Feb. 8, 1987</u> , that (I) (we) lost saw the deceased alive on <u>Feb. 8, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Sharon Pourmontal</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2-8-87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GHASSEM POURMONTAL</u>		22e. ADDRESS <u>Balto. County Gen. Hospital</u>							
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE <u>2/12/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Co., Md.</u>			
24. FUNERAL DIRECTOR <u>Prudzikski Funeral Home</u>		25a. DATE REC'D. BY REGISTRAR <u>FEB 09 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>					

Johns Helen Woodland

Salisbury County

x

224

Germany

Salisbury County Jail, Salisbury, Maryland

303 1st Ave. SE

224

Salisbury

Thomas Woodland

303 1st Ave. SE, Salisbury, Maryland

FEB 09 1967

Salisbury County Jail, Salisbury, Maryland

045948 MAR 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

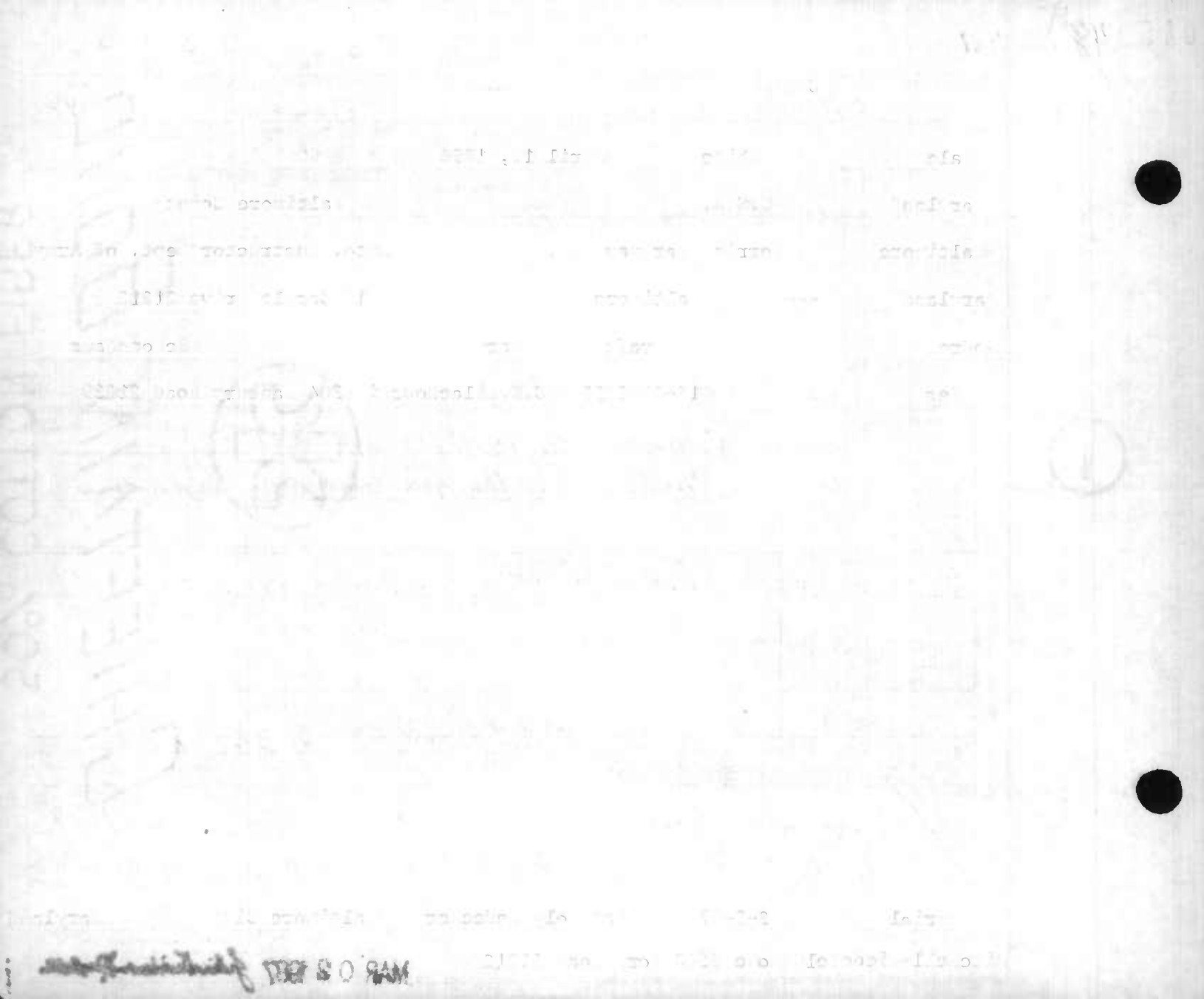
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and tentatively filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 3 and 4 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner who signed item 18 should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES HENRY KRAFT</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>2/26/87</b>		2b. HOUR <b>9 P.M.</b>					
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 19, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Perring Parkway N.H.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auto. Instructor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Army</b>				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Baltimore</b>	13d. STREET ADDRESS / ZIP CODE <b>514 Castle Drive 21212</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Kraft</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Schoenhaus</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WWI 218-07-2632</b>		17. INFORMANT ADDRESS <b>C.K. Pilachowski 6304 Banbury Road 21239</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST.</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>CHRONIC Obstructive Pulmonary DISEASE.</b> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SINGLE DEMENTIA. ASCVD. CHRONIC BRAIN SYNDROME</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9 P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/26/87</b> to <b>2/26/87</b> , that (I) (we) last saw the deceased alive on <b>2/26/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Anthony F. Carozza</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/27/87</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Anthony F. CAROZZA</b>		22e. ADDRESS <b>4214 MANORWOOD DR. GLEN ARM MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-2-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>					
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 02 1987</b>					
		25b. REGISTRAR'S SIGNATURE <b>John B. ...</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified and a report filed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>EUGENIA I KUREK</b>					2a. DATE OF DEATH MONTH <b>2</b> DAY <b>13</b> YEAR <b>87</b>		2b. HOUR <b>5:35</b> <sup>PM</sup>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov:11, 1911</b> YEAR		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U SA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Baltimore Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Accountant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6 Ecoway Ct. Apt.3 B 21204</b>	
14. FATHER'S NAME FIRST <b>Peter</b> MIDDLE <b>Kurek</b> LAST				15. MOTHER'S MAIDEN NAME FIRST <b>Stella</b> MIDDLE <b>Draszkiewicz</b> LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>213-05-6898</b>		17. INFORMANT ADDRESS <b>Mrs. Lorretta Krogmann Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Small bowel obstruction with perforation</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/26</b> 19 <b>86</b> to <b>2/13</b> 19 <b>87</b> that (I) (we) last saw the deceased alive on <b>2/13</b> 19 <b>87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R. Breiteneker</i> MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>2/14/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RUDIGER BREITENECKER, M.D.</b>				22e. ADDRESS <b>6701 N. Charles Street, Towson MD 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb.17,1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dundalk Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 17 1987</b>		25b. REGISTRAR'S SIGNATURE <i>John Gordon-Rudner</i>			



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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. CERTAIN PAGE SACK YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT FORM. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

03186

1. DECEASED NAME (TYPE OR PRINT)			FIRST O.			MIDDLE			LAST			2a. DATE KNOWN OF DEATH MATED			MONTH DAY YEAR			2b. HOUR		
EDWARD LANCASTER												February 4 1987			7:00 PM					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7a. DATE PRONOUNCED DEAD			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. BALTIMORE CO MD.					
M	W	10-12-26	60 YRS.			February 4 1987						BALTIMORE CO								
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			12. CITY OR TOWN OF DEATH			13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			15. KIND OF BUSINESS OR INDUSTRY			16. FEO. Gov't					
Maryland			Baltimore			ST JOSEPH HOSPITAL														
17a. STATE			17b. COUNTY			17c. CITY OR TOWN			17d. INSIDE CITY LIMITS?			17e. STREET ADDRESS			17f. ZIP CODE					
MD			BALTIMORE			GLEN ARM			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4710 LONG GREEN ROAD			21057					
18. FATHER'S NAME			19. MOTHER'S MAIDEN NAME			20. WAS DECEASED EVER IN U.S. ARMED FORCES?			21. SOCIAL SECURITY NO.			22. INFORMANT			23. ADDRESS					
G. SORLZ			IRINE			YES			220 22 8338			FAMILY RECORDS			COLLIGAN					
18a. IMMEDIATE CAUSE (a)			18b. DUE TO, OR AS A CONSEQUENCE OF			18c. DUE TO, OR AS A CONSEQUENCE OF			18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Acute Myocardial Infarction			Coronary Insufficiency			ASCD			Sudden											
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			25. DATE OF OPERATION			26. CONDITION FOR WHICH OPERATION WAS PERFORMED?			27. AUTOPSY?											
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
28a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			28b. TIME OF INJURY			28c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
			HOUR A.M. MONTH DAY YEAR																	
29a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			29b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			29c. LOCATION														
						CITY OR TOWN			COUNTY			STATE								
30. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from:			Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
31. ACTUAL SIGNATURE			32. TITLE (CAPACITY)			33. DATE SIGNED														
Blair T. O'Connell			M.D. Deputy			2/4/87														
34. EXAMINER'S NAME (TYPE OR PRINT)			35. ADDRESS																	
36a. BURIAL, CREMATION, REMOVAL (SPECIFY)			36b. DATE			36c. NAME OF CEMETERY OR CREMATORY			36d. LOCATION			36e. COUNTY			36f. STATE					
BURIAL			2-7-1987			ST. JOHN'S CEM.			Long Green			BALTO.			MO					
37. FUNERAL DIRECTOR NAME			37b. ADDRESS			37c. DATE REC'D. BY REGISTRAR			37d. REGISTRAR'S SIGNATURE											
EVANS CHAPEL OF MEMORIES HARFORD			8800 ROAD			FEB 10 1987			R. R. R. R.											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

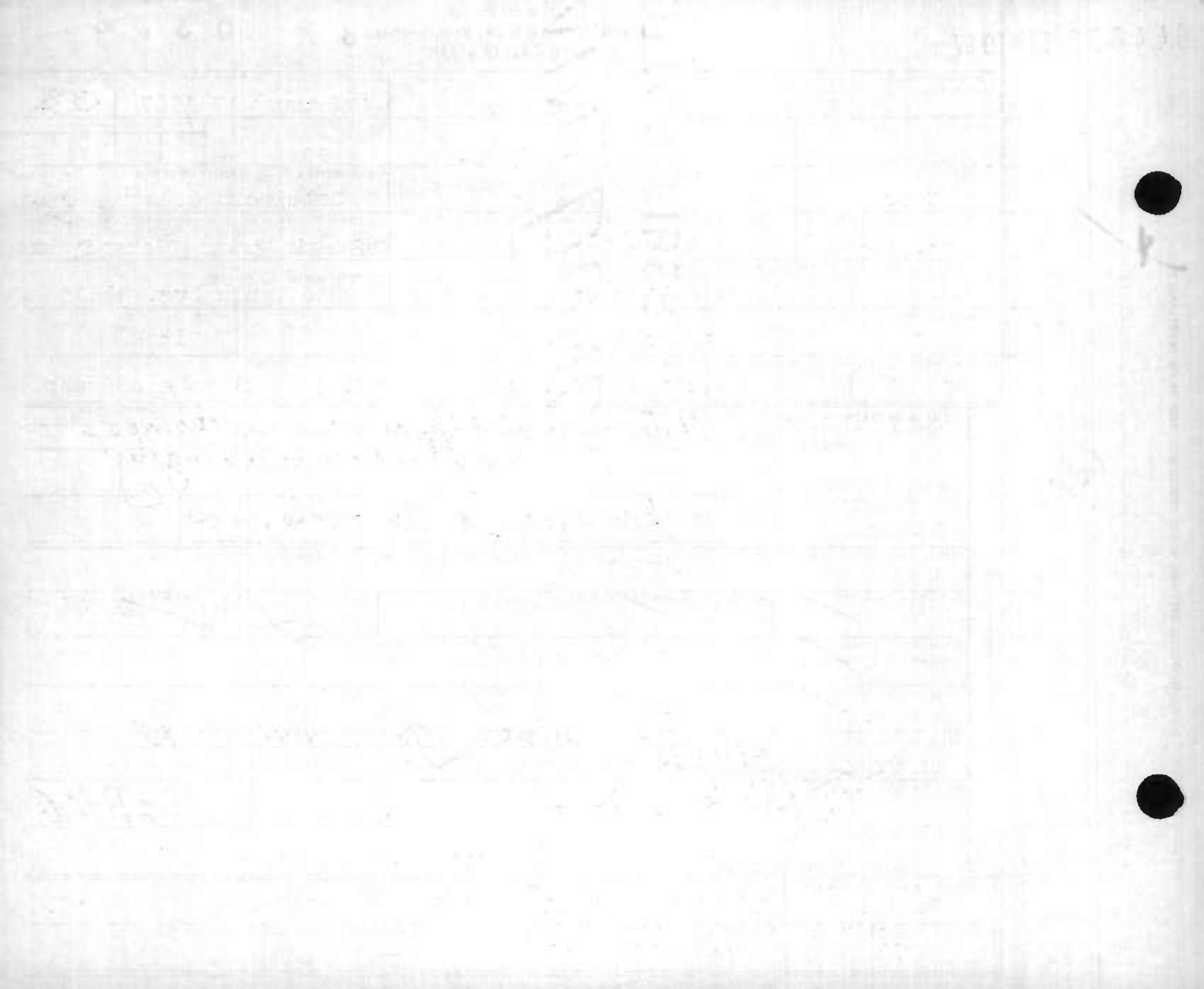
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Anna Lasinsky</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 17 1987</b>			2b. HOUR <b>3:30 AM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 15 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Czech.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9626 Tenth Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cafeteria Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Slater System</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>9626 Tenth Ave. 21234</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Matthew Lehecka</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Vitek</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>219-20-8543</b>		17. INFORMANT ADDRESS <b>Margaret Bach (dghtr) same address</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>arrhythmia + Cardiac injury</b> (b) <b>Generalized atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>June 19 78</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Md.</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/4/85</b> to <b>June 19 78</b> , that (I) (we) last saw the deceased alive on <b>3/4/85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (last) told next of kin the body after death.										
22b. SIGNATURE <b>Dr. Frank Kasik</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/17/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Frank Kasik</b>			22e. ADDRESS <b>9005 Harford Rd.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2/20/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bohemian Nat'l</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL HOME NAME <b>Schmunek Funeral Home, Inc.</b> <b>3331 Brehms Lane, Balto. Md. 21213</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 17 1987</b>		25b. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

BP



4905 FEB 23 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

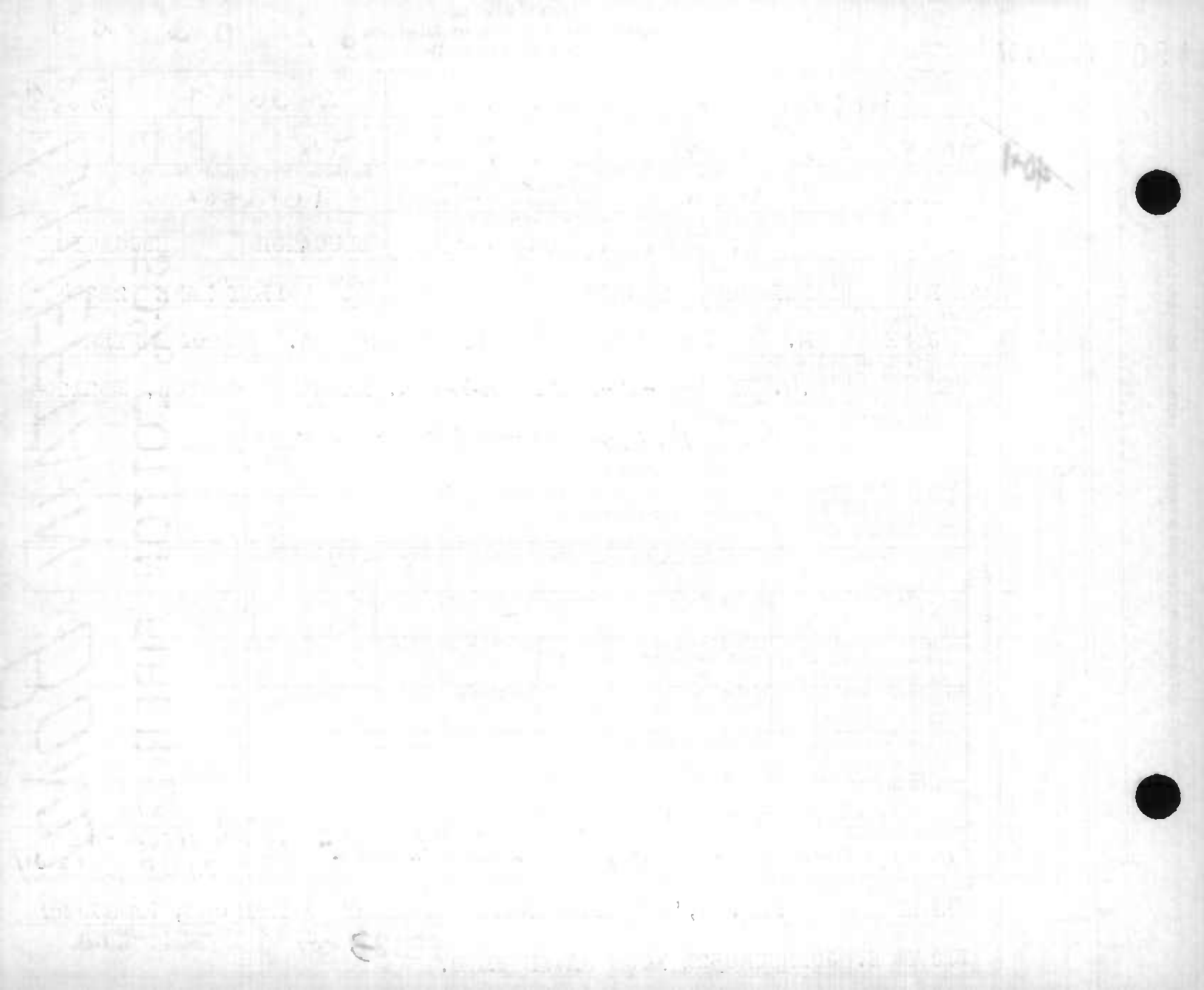
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 87 03 / 88			
1- REGISTRAR FOR STATE 2/26/87 rja				FEB 23 1987			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY L LAWRENCE				2a DATE OF DEATH MONTH DAY YEAR 2-20-87		2b HOUR 10:05 AM	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR NOV. 8, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH TOWSON Baltimore County MD	
10 CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Joseph Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EDUCATOR		12b KIND OF BUSINESS OR INDUSTRY EDUCATION	
13a STATE MARYLAND				13b COUNTY BALTIMORE		13c CITY OR TOWN TOWSON	
14 FATHER'S NAME FIRST MIDDLE LAST JOHN M. LAWRENCE				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE A. GRUELLEMEYER			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 11		17 INFORMANT ADDRESS LORRAINE R. LAWRENCE TOWSON, MD 21204			
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, Stroke &amp; Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Natividad D. de Leon M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/20/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) NATIVIDAD D. DE LEON		22e ADDRESS C/O ST. JOSEPH HOSPITAL, 813 STAGS H TOWSON, MD. 21204					
23a BURIAL, CREMATION, REMOVAL (CHECK ONE) CREMATION		23b. DATE FEB. 21, '87		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND	
24 FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON				25 DATE RECD BY REGISTRAR FEB 23 1987		25 REGISTRAR'S SIGNATURE John Borden-Randall	

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

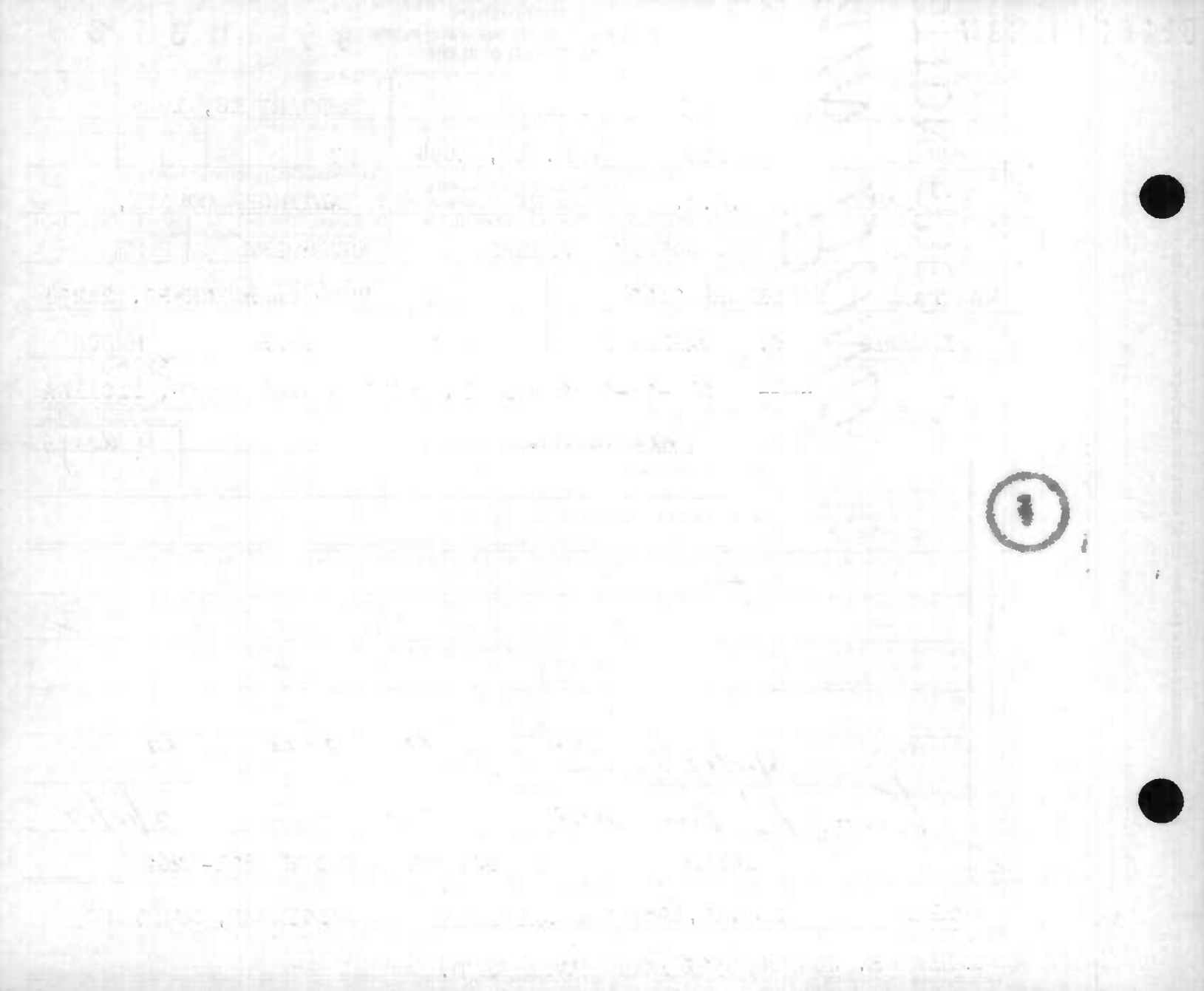
DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03 / 89  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SADIE BELLE LAYTON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 18, 1987</b>		2b. HOUR M
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 18, 1894</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>	
10 CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>21234</b>	13d. STREET ADDRESS / ZIP CODE <b>7700 OAKLEIGH RD. 21234</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PINCKNEY C. TARLETON</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA BELL MASON</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-30-3499</b>		17 INFORMANT ADDRESS <b>JANE L. DONOHUE VERO BEACH, FLORIDA 32960</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) _____	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>87</u> , to <u>2-18</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>2/18/87</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Frank J. Kuehn</i>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/18/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KUEHN</b>		22e. ADDRESS <b>7600 OSLER DRIVE 821-8262</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>FEB. 19, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MARYLAND</b>					
24. FUNERAL DIRECTOR NAME <b>WILLIAM E. JOHNSON</b>		ADDRESS <b>8521 LOCH RAVEN BLVD.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 20 1987</b>	
				25b. REGISTRAR'S SIGNATURE <i>Donald R. Kuehn</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked over item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Mildred M. LEE</b>		2b. DATE OF DEATH MONTH DAY YEAR <b>February 12th 87</b>		2c. HOUR <b>6.30 P<sub>M</sub></b>	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 31 99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST JOSEPH Hosp. 7630 York Rd</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>	
13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1312 Providence Rd. 21204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Eugene Solomon Sweeney</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Estelle Taylor</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-10-5582</b>		17. INFORMANT <b>Mrs. Raymond Stone</b>		ADDRESS <b>Marlton, N.J. -8 Elizabeth Ct., S.08053</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Respiratory Failure**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Dehydration**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

**S/p Colostomy - Angina**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTAINING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>Nov</b> , 19 <b>86</b> , to <b>2/12/87</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2/12/87</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.							
22b. SIGNATURE <b>Vuong Nguyen</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/12/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VUONG NGUYEN</b>		22e. ADDRESS <b>6331 Baldis Rd Balto Md 21206</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-16-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville, Balto., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>		ADDRESS <b>Towson, Md. 21204</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 17 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Lia Davidson-Randall</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove "Burial" papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

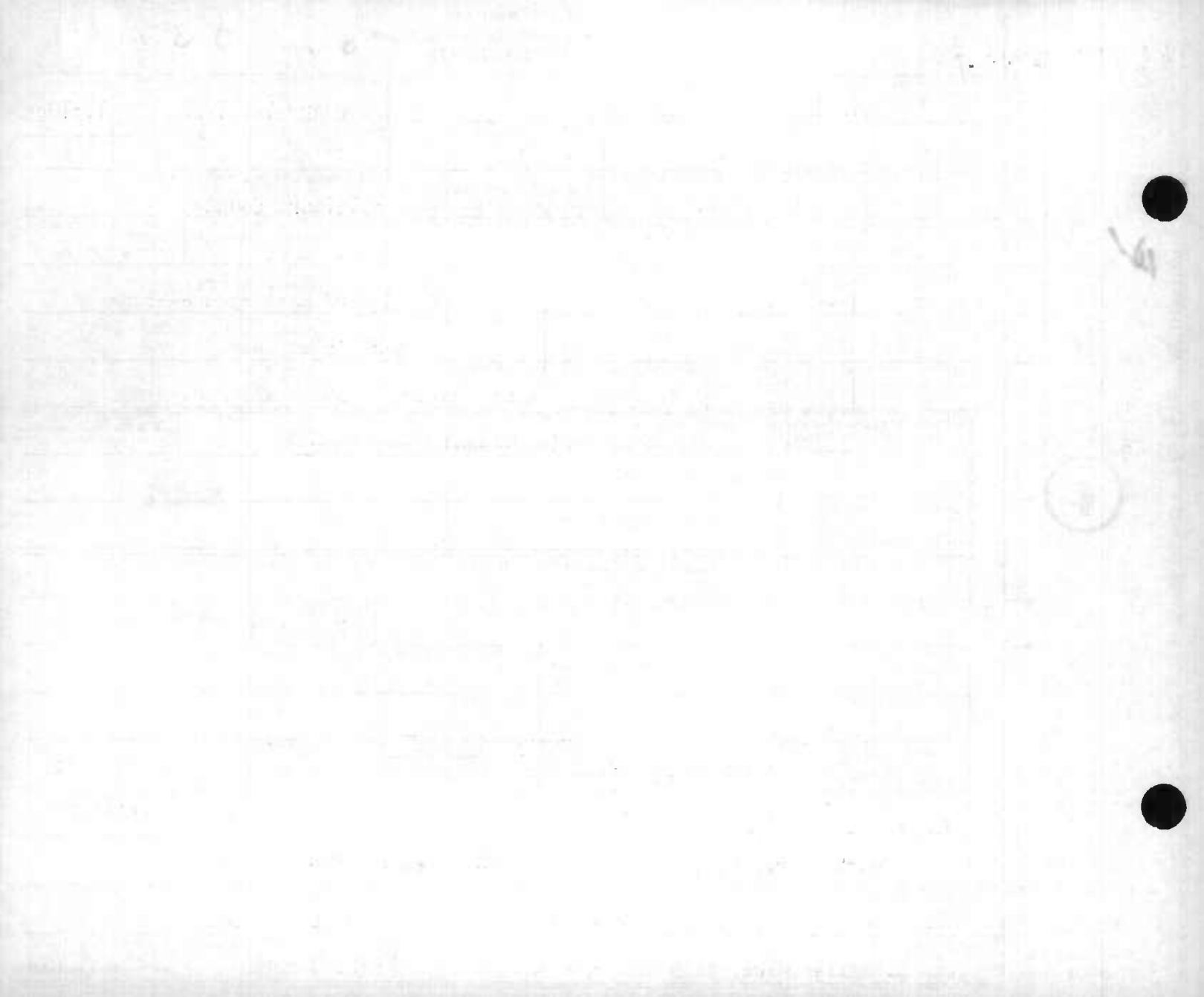
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8703791

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Virginia A. LIMANSKY			2a. DATE OF DEATH MONTH DAY YEAR February 14, 1987			2b. HOUR 11:10pm			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6-17-1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSULTANT		12b. KIND OF BUSINESS OR INDUSTRY Van's Spices	
13a. STATE Maryland			13b. CITY OR TOWN Balto.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5803 East Avenue-21206		
14. FATHER'S NAME FIRST MIDDLE LAST Leicester C. Lewis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Baldwin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 112-22-7981		17. INFORMANT ADDRESS Igor Limansky - 5803 East Ave.-21206					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper Gastrointestinal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I (this hospital) attended the deceased from February 14, 1987, to February 14, 1987, that I (we) last saw the deceased alive on February 14, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.									
22b. SIGNATURE Keith W. Parker				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 2/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Keith Parker M.D.				22e. ADDRESS 9000 Franklin Square Drive					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2-18-87		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME John C. Miller, Inc.-6415 Belair Road				25a. DATE REC'D. BY REGISTRAR FEB 17 1987		25b. REGISTRAR'S SIGNATURE Davidson-Randall			



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

87 03192  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Margaret M. Lipinski</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 28, 1987</b>			2b. HOUR <b>M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 30, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City Co. MD.</b>			
10. CITY OR TOWN OF DEATH <b>Dundalk</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>106 Wells Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Gilbert Dunlap</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ollie Howell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>239-34-1725</b>		17. INFORMANT ADDRESS <b>Anthony J. Lipinski, Same As #13e 21222</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Metastatic Breast Cancer**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**Positive exposure to human Immunovirus**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> SHOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Eddie Nahkuda M.D.</b>				DEGREE <b>ATTENDING PHYSICIAN</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>Stella Maris Hospice, Towson, Maryland</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-2-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Of Jesus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dundalk, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck Funeral Home, Inc. Dundalk, Maryland</b>				25a. DATE RECD. BY REGISTRAR <b>MAR 04 1987</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



60

6

THE UNIVERSITY OF CHICAGO  
LIBRARY

COMMUNICATIONS



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 03193	
1. DECEASED NAME (TYPE OR PRINT) <del>Herbert</del> Herbert Livingston			2a. DATE OF DEATH MONTH DAY YEAR 2 27 87		2b. HOUR 952 AM	
3. SEX MALE	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR 8 11 26	6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8a. BIRTHPLACE COUNTRY MARYLAND	8b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME AND ADDRESS OF INSTITUTION) BALTIMORE COUNTY GEN. HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COLLECTOR		12b. KIND OF BUSINESS OR INDUSTRY INSTALLMENT	
13a. STATE MARYLAND			13b. COUNTY BALTO.	13c. CITY OR TOWN OWINGS MILLS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY LIVINGSTON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE SHANK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII-NAVY 220-12-8397	17. INFORMANT MRS. MURIEL LIVINGSTON 12 CORNBURY CT. OWINGS MILLS, MD 21117			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>500 AN.</u> <u>10 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus.</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> , 19 <u>87</u> , to <u>2/27</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Lawrence Solomon</u> MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/27/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE SOLOMAN		22e. ADDRESS 600 REISTERSTOWN RD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR. 1, 1987		23c. NAME OF CEMETERY OR CREMATORY SHAAREI ZION		23d. LOCATION ROSDALE BALTO. STATE MD
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR MAR 05 1987		25b. REGISTRAR'S SIGNATURE <u>Lia Jindani-Rudman</u>

BP

4-11-00  
To the Honorable  
Commissioner of the General Land Office  
Washington, D.C.  
Dear Sir:  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the application for a patent for an improvement in a method of measuring land, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
J. H. [Signature]  
Assistant Commissioner

045627 MAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the Division of Vital Records, Department of Health and Mental Hygiene, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other factor in event, the medical examiner must be notified of one.

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87

03194

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DELMAR LOGAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 23, 1987</b>			2b. HOUR <b>7<sup>10</sup> P.<sup>M</sup></b>				
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 27 1933</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH'S HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SPRAY PAINTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>ABBEY DRUM CO.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH LOGAN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MAMIE BROWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>213-30-9861</b>		17. INFORMANT MRS. <b>BALTIMORE, MO. 21215</b> <b>RUTH J. LOGAN 3706 PARK HEIGHTS AVE.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADENOCARCINOMA OF LUNG, METASTATIC</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HEMIPLEGIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN</b> <b>4 MONTHS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <b>HEMIPLEGIA</b>										
19a. DATE OF OPERATION <b>—</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>—</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) <b>—</b>				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>				
22a. I certify that (1) (this hospital) attended the deceased from <b>2-2</b> 19 <b>87</b> , to <b>2-23</b> 19 <b>87</b> , that (1) (we) lost saw the deceased alive on <b>2-23</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Carlton C. Greene MD</b>						22c. DATE SIGNED <b>2-24-87</b>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CARLTON C. GREENE</b>	
22e. ADDRESS <b>1717 GWYNW OAK AV.</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>2/28/1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MARYLAND</b>		
24. FUNERAL HOME OR NAME ADDRESS <b>NUTTER &amp; SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MO. 21216</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Denson-Randee</b>		

Dear Sir:  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the application for a patent for the invention of a new and improved method of producing artificial flowers. The same has been referred to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours very truly,  
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DMMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Goldie V. Lovett			2a. DATE OF DEATH MONTH DAY YEAR February 26, 1987		2b. HOUR M
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Sept. 12, 1891		6. AGE - (IN YEARS LAST BIRTHDAY) 95 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perring Parkway Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST George Hale			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Snyder		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 44 9789	17. INFORMANT ADDRESS 13707 Summer Hill Dr Mr. Leroy W. Lovett Phoenix, Md. 21131		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA. OF COLON DUE TO, OR AS A CONSEQUENCE OF (b) ANEMIA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Celar E. Parra MD				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Celar E. Parra, MD				22e. ADDRESS 7122 Harford Road Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/2/87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.				25a. DATE REC'D. BY REGISTRAR MAR 02 1987	
				25b. REGISTRAR'S SIGNATURE	

BP

RECEIVED  
JAN 10 1961

Mr. J. Edgar Hoover

Director, FBI

Dear Sir:

Enclosed for you are

two copies of

a report of the

San Francisco

Office of the

Attorney General

dated 1/5/61

re: [illegible]

Very truly yours,  
[illegible signature]

(1)

**RECEIVED FBI 8:00 AM**



BP

DHMM - 16 60M 7/84  
(VRA 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03196

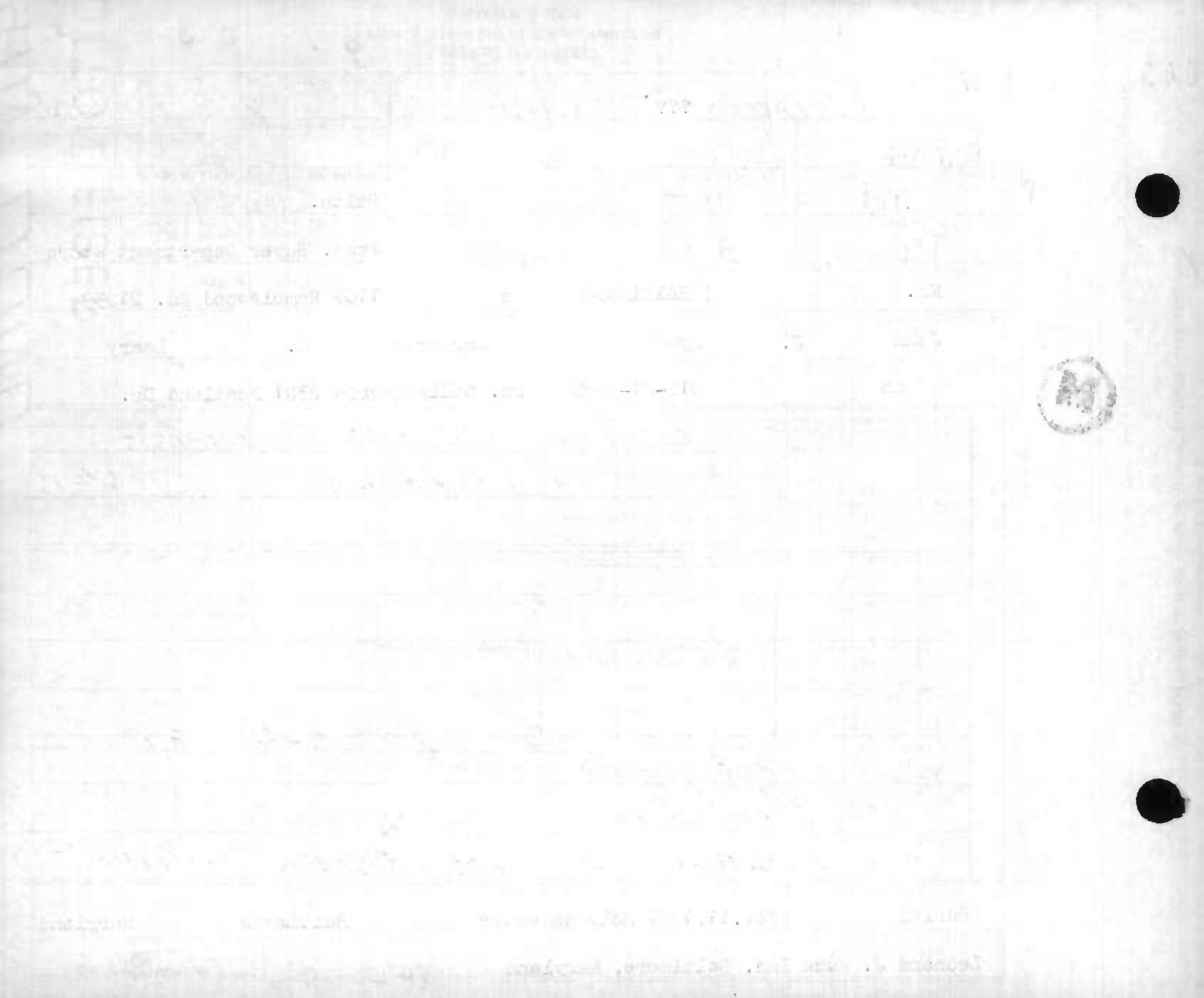
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Elizabeth F. LYNG</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2 8 87</i>			2b. HOUR MIN. <i>6:00 A</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 4 1908</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>78</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. County</i> MD	
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St Joseph Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Asst. Buyer Department Store</i>	
13a. STATE <i>MD.</i>		13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John J. Lyng</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret M. Leary</i>		16. STREET ADDRESS / ZIP CODE <i>1102 Ramblewood Rd. 21239</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>216-01-8283</i>		17. INFORMANT ADDRESS <i>Mrs. Della Harris 2301 Pentland Dr.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBROVASCULAR THROMBOSIS</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>and STROKE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Days.</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>1-5- 19 87</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-5-</i> 19 <i>87</i> , to <i>2-8-</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>2-8-</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>87</i>							
22b. SIGNATURE <i>A.H. Ghiladi</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A.H. GHILADI, MD.</i>		22e. ADDRESS <i>7600 OSLER Dr. Towson</i>		22f. ZIP CODE <i>21204</i>			
23a. BURIAL, CREMATION, REMOVAL (TYPE) <i>Burial</i>		23b. DATE <i>Feb. 11, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Leonard J. Ruck Inc. Baltimore, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 11 1987</i>			
25b. REGISTRAR'S SIGNATURE <i>Alia Tuckson-Randall</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon copy and 2. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8703797  
REG. NO.

1. FOR  
STATE  
REGISTRAR

3. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
IDA		L.		MACIEJEWSKI	FEBRUARY 04, 1987				M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE	WHITE	May 6, 1903		83	YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania	U.S.A.			BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
LANSLOWNE	2708 ARBUTUS AVENUE				HOUSEWIFE		OWN HOME		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
MARYLAND	BALTIMORE	LANSLOWNE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	2708 ARBUTUS AVENUE 21227				
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
JOSEPH LAVONIS				UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (S, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO						THEADORE KRUHMAN 2708 ARBUTUS AVENUE			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Patience myocardial infarction</i>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>of 2nd</i>		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>coron</i>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Dr. Ashuk Chatterjee</i>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ASHUK CHATTERJEE, M.D.	22e. ADDRESS 3927 ANNAPOLIS ROAD 21227		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2/7/87	Loudon Park Cemetery	Baltimore City, Maryland
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
AMBROSE FUNERAL HOME 1328 SULPHUR SPRING ROAD		FEB 6 1987 <i>Julia Gordon-Randall</i>	

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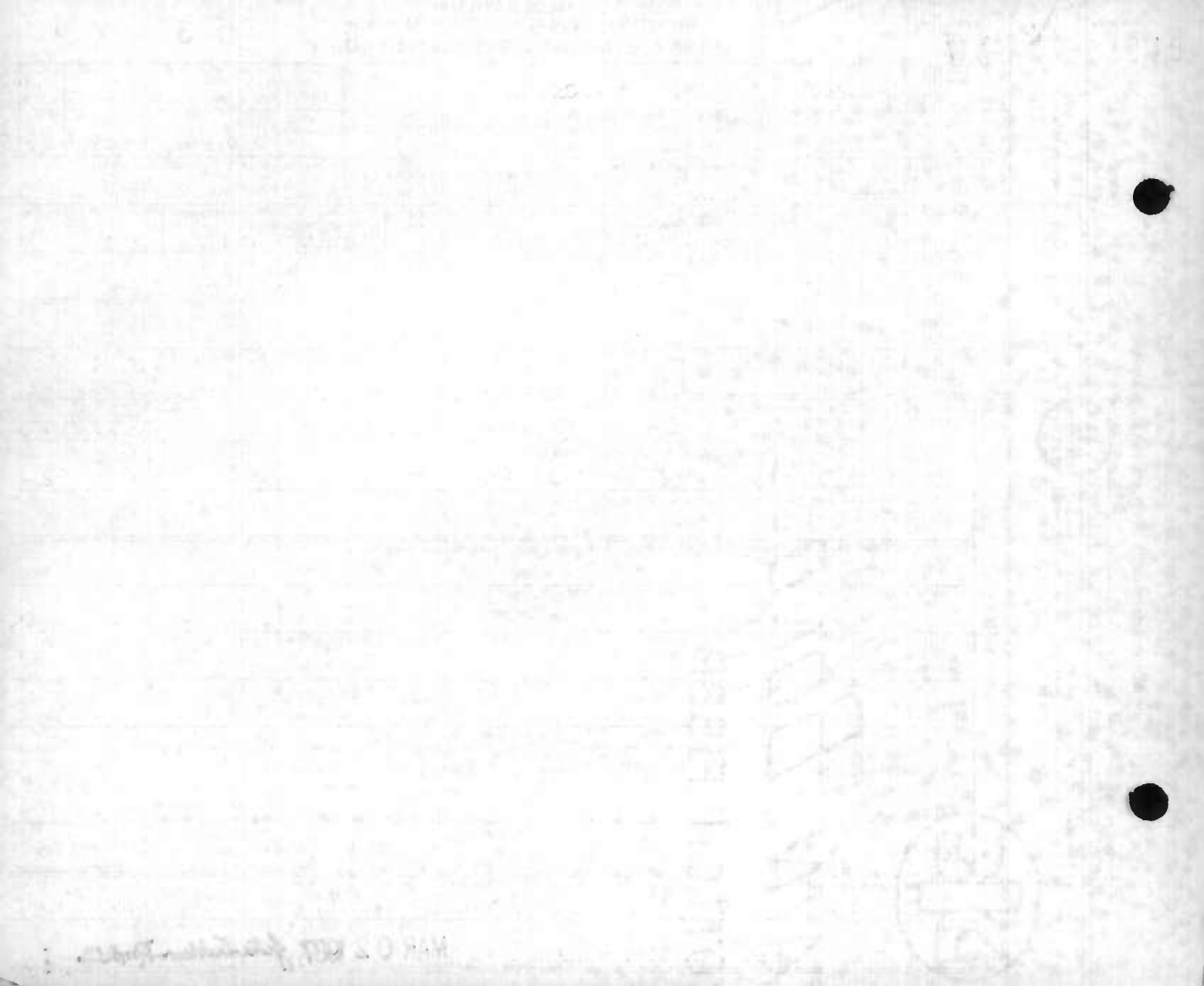
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM WM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03198	
1. DECEASED NAME (TYPE OR PRINT) PETER P. MACKOWIAK SR.										2a. DATE KNOWN OF DEATH MATED February 27 1987	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6 2 10		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Cockeysville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5 Beehive Court Apt. E				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Furniture Sales		12b. KIND OF BUSINESS OR INDUSTRY Sears	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Apt. E 5 Beehive Place 21030	
14. FATHER'S NAME FIRST MIDDLE LAST Peter Mackowiak						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Herness					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 179-07-1671		17. INFORMANT ADDRESS Peter P. Mackowiak, Jr. 3001 Franklin 21047					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cadaveric Arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>ASCD</u> (b) <u>ASCD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCD</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Change of location</u> <u>Sweden</u> <u>5 ty</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Charles P. Donnell</u>						TITLE (SPECIFY) Deputy			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/3/87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.						24b. ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR MAR 02 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

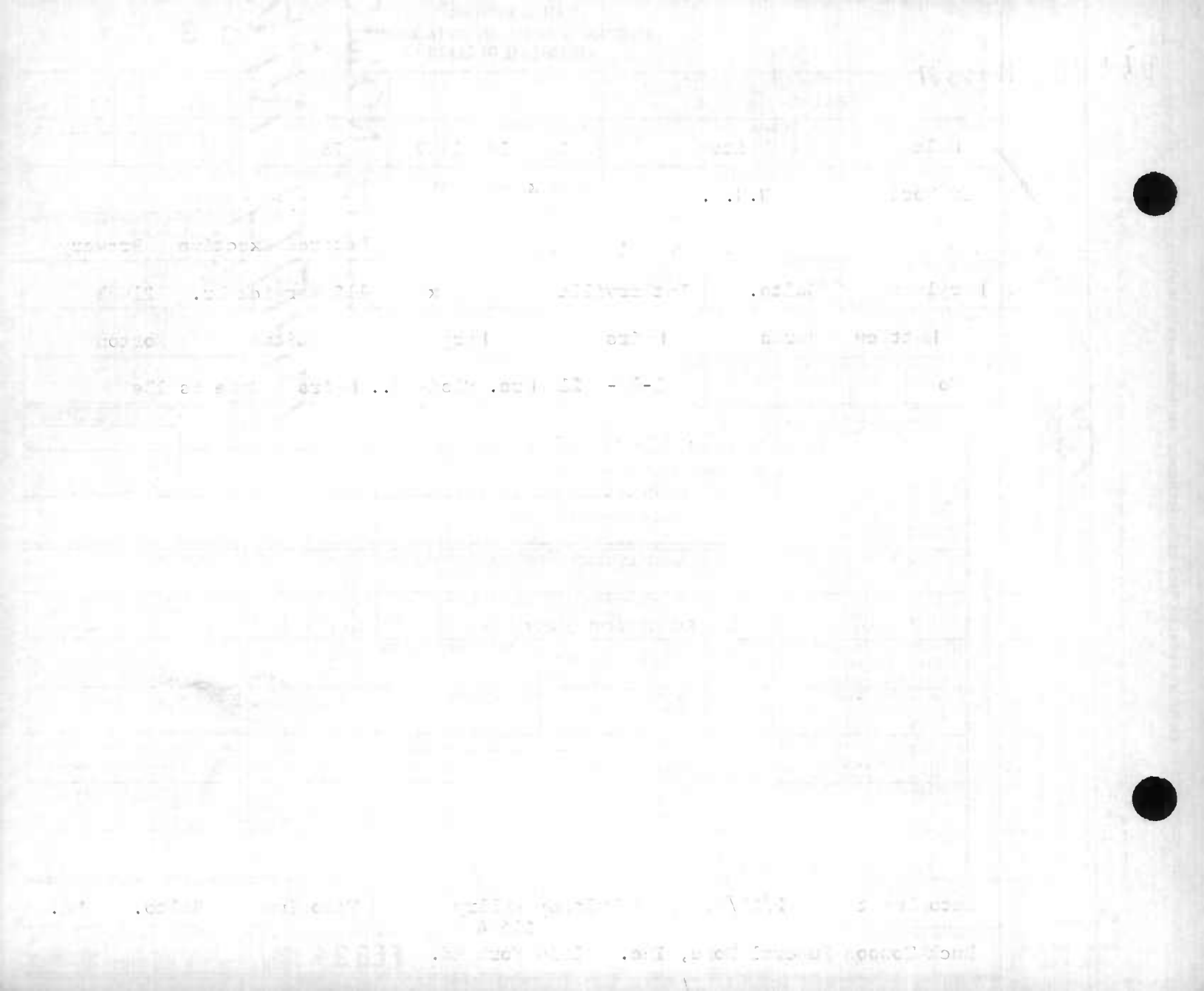


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2. Page 1 will be filed with 10472 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. Page 2 will be filed with 10472 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic death, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Matthew L. Mairs						2a. DATE OF DEATH MONTH DAY YEAR 02 20 87		2b. HOUR 8:50 a.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 10 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Executive		12b. KIND OF BUSINESS OR INDUSTRY Brewery	
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 112 Warwick Dr. 21093	
14. FATHER'S NAME FIRST MIDDLE LAST Matthew Burns Mairs				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Anita Norton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 091-05-0621		17. INFORMANT ADDRESS Mrs. Elsie E.. Mairs Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CA Pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months
19a. DATE OF OPERATION 2/7/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Endoscopy for bleeding				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Sompalli Prasad				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Prasad Sompalli, M.D.				22e. ADDRESS G.B.M.C.					
23a. BURIAL, CREMATION, REMOVAL Entombment		23b. DATE 2/23/87		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium Balto. Md.			
24. FUNERAL DIRECTOR Ruck Towson Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR FEB 24 1987		25b. REGISTRAR'S SIGNATURE			





044203 FEB

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03800

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES ALLEN MANSFIELD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 9, 1987</b>			2b. HOUR <b>7:40 P.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 19 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>72</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD			
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <b>2832 PLAINFIELD ROAD / 21222</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>HENRY MANSEFIELD</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Isabel Sullivan</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>217 07 2630</b>			17. INFORMANT ADDRESS <b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIOVASCULAR ACCIDENT</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DECUBITUS ULCER, CHRONIC RENAL FAILURE</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b> <b>1 YEAR</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 10, 1986</b> , to <b>FEBRUARY 9, 1987</b> , that (I) (we) last saw the deceased alive on <b>FEBRUARY 9, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Peter V. Juvan</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2-10-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER V. JUVAN, M.D.</b>			22e. ADDRESS <b>VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>2/14/1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland 21202</b>		
24. FUNERAL DIRECTOR NAME <b>Walter Brooks Bradley, Inc. Balto., Md. 21222</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Dodson-Randall</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other condition, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 3 8 0 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Attilio Marcon</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>2-3-87</b>		2b. HOUR <b>10:25 P.</b>	
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 29, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>	
10. CITY OR TOWN OF DEATH <b>LOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bricklayer Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Parkville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Not Known</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Not Known</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 217-22-7899</b>		17. INFORMANT ADDRESS <b>21224 LeRoy E. Gerding Jr. 1107 North Pt. Blvd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stomach Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Adel S. El-Hennawy MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2-3-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Adel S. EL-Hennawy</b>		22e. ADDRESS <b>S J H</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		23b. DATE <b>Feb 6 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>			
25a. DATE REC'D. BY REGISTRAR <b>FEB 6 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Lundgren</b>			



044311 FEB 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

03802

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR				7b. HOUR	
Samuel B. MARRS						February 8, 1987				9:35 R	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		MONTH DAY YEAR 01 28 09		78 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rosedale		Franklin Square Hospital						Carpenter		Self	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MD		Balto.		Rosedale		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9210 Oswald Way 21237			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Robert Lee Marrs				FIRST MIDDLE LAST Jakage Peery							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
N/A				N/A		234-28-8377 Meanne A. Marrs Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Atherosclerotic cardiovascular disease											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (he) (this hospital) attended the deceased from December 28, 19 86, to February 9, 19 87, that (he) (we) saw the deceased alive on February 9, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE						22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
G. Johnson, M.D.		9000 Franklin Square Drive, 21237									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		02/10/87		Security Process		Baltimore Balto. MD					
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE			
Baltimore, MD 21228 Cremation Society of Maryland								FEB 13 1987 John Davidson-Rosedale			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESHOT ST., BALTIMORE, MARYLAND 21201



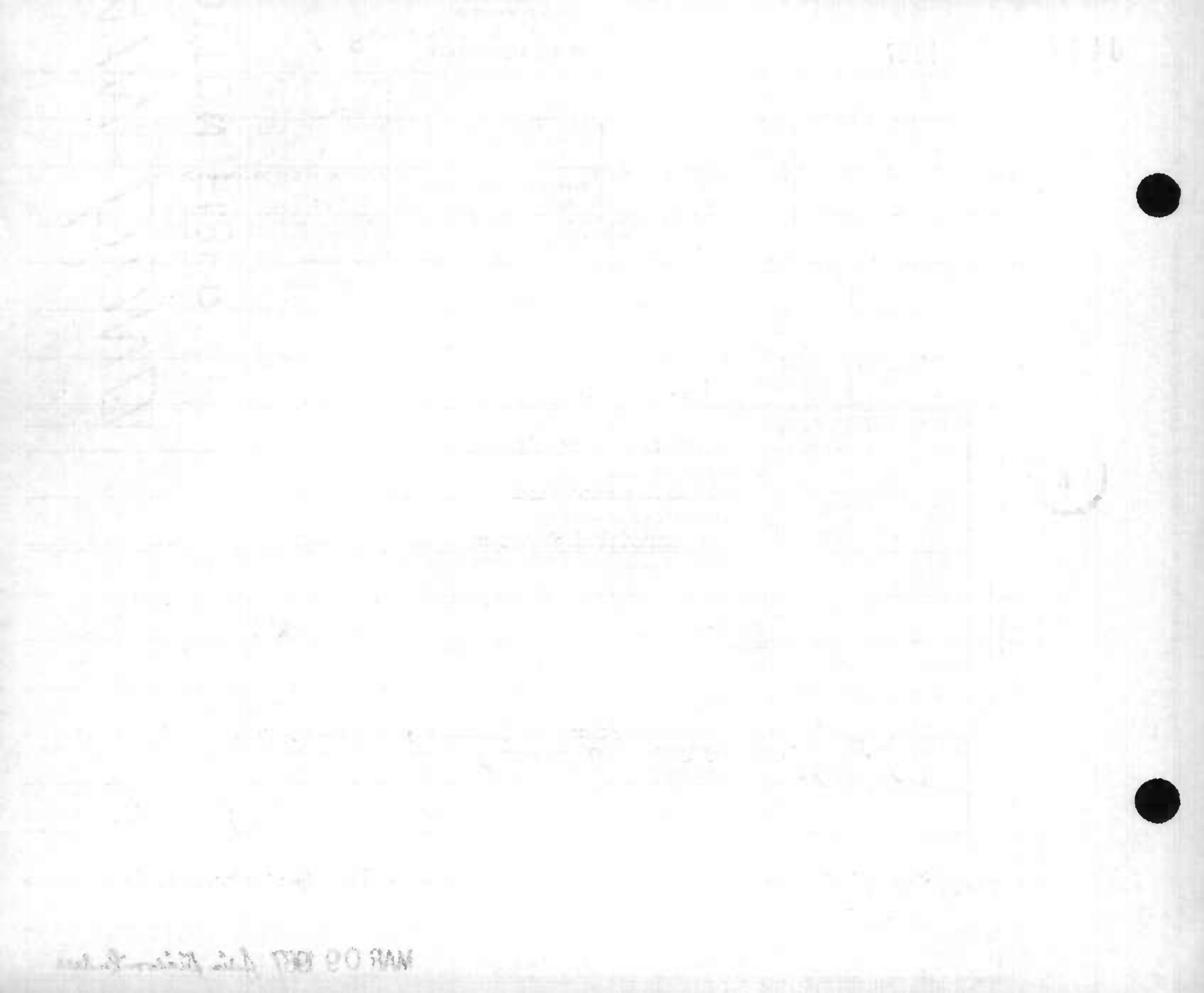
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page and return it to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) Anne MARTIN					2a. DATE OF DEATH MONTH DAY YEAR February 26, 1987					2b. HOUR 4:00 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 2 05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.					13b. COUNTY BALTO		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Fleckenstein					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Smith					13e. STREET ADDRESS / ZIP CODE 6600 Ridge Rd. 21237	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-03-4808		17. INFORMANT 2909 Valley Brook Ct. Mr. Norman Martin, Jr. Kingsville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mitral Regurgitation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 16, 87 to February 26, 87, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 26, 1987, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Chet Wyman</i>				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chet Wyman MD				22e. ADDRESS 9000 Franklin Square Dr., 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 2-27-87		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME State Anatomy Board					ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR MAR 09 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Tindon-Randall</i>		





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 7 0 3 8 0 4  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Peter W. Martin		2a. DATE OF DEATH MONTH DAY YEAR 2-5-87		2b. HOUR 3:05 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR NOV. 13, 1908	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Falls River Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
10. CITY OR TOWN OF DEATH Pikesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOW IN SUCH FACILITY, GIVE STREET ADDRESS) Pikesville Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Accountant		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. CITY OR TOWN Balto.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Martin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sermota		13d. STREET ADDRESS / ZIP CODE 922 Shirley Manor Road 21136	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 057-07-9879		17. INFORMANT ADDRESS Mrs. Audrey A. Martin Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxins due to C. coli</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia LL</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aspiration</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11-86</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>83</u> , 19 <u>83</u> , to <u>1-22-87</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED <u>2-6-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOSEPH RECTOR, MD</u>		22e. ADDRESS <u>17 CHARLESTOWN PARK RD</u>			
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE Feb. 6, 87		23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation	
23d. LOCATION Hampstead		COUNTY Md.		STATE	
24. FUNERAL DIRECTOR NAME Eline Funeral Home		ADDRESS Reisterstown, Md. 21136		25a. DATE REC'D. BY REGISTRAR FEB 09 1987	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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4 5 5 5 9 FEB 27 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 7 0 3 8 0 5  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Raymond Douglas MATHENA			2a. DATE OF DEATH MONTH DAY YEAR February 24 1987			2b. HOUR 10:01 a.m.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 29, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Rosedale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor		12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Ballard Jackson Mathena			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mannie Sue Cooper			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 235-16-2207	
17. INFORMANT ADDRESS Inez Addie Mathena 108 North Janney Street										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atheroclerotic Cardio-vascular Disease. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I (the hospital) attended the deceased from February 22 1987 to February 24 1987, that I (we) last saw the deceased alive on February 24 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) did not view the body after death.										
22b. SIGNATURE W. Kirk			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/24/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. Kirk M.D.			22e. ADDRESS 9000 Franklin Square Drive., Balt. 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 27, 1987		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Middle River Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc. Dundalk, Md. 21222			25a. DATE REC'D. BY REGISTRAR FEB 25 1987			25b. REGISTRAR'S SIGNATURE Julia Dendron-Randall				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the deceased's file. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner must be notified at once.

20 03



Feb 25 1961

045527 FEB 27 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 03806

1. DECEASED NAME (TYPE OR PRINT)			FIRST CHARLES			MIDDLE O.			LAST MATTHEWS			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR			2b. HOUR								
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR May 25 1923			6. AGE (IN YEARS) (LAST BIRTHDAY) 63 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 20 1987			7d. HOUR 10 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.														
10. CITY OR TOWN OF DEATH Reisterstown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Blvd. & Nicodemus Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman			12b. KIND OF BUSINESS OR INDUSTRY														
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Reisterstown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 837 Ivydale Ave. 21136											
14. FATHER'S NAME FIRST MIDDLE LAST John O. Matthews						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa O. Donovan																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			(IF YES, GIVE WAR OR DATES) WW II			16b. SOCIAL SECURITY NO. 216-16-1932			17. INFORMANT Mrs. Maria A. Matthews			ADDRESS (Same)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR <u>9</u> MONTH <u>2</u> DAY <u>20</u> YEAR <u>1987</u> P.M.						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto/truck collision.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road						21f. LOCATION STREET CITY OR TOWN COUNTY STATE Franklin Blvd. & Nicodemus Rd., Balto. MD											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Gregory R. Kauffman, M.D.						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 2-21-87											
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS 111 Penn St., Balto., MD 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 2-24-87						23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet. Cem.						23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Balto. Md.					
24. FUNERAL DIRECTOR NAME Eline Funeral Home						ADDRESS Reisterstown, Md.						25a. DATE REC'D. BY REGISTRAR FEB 23 1987						25b. REGISTRAR'S SIGNATURE John P. ...					

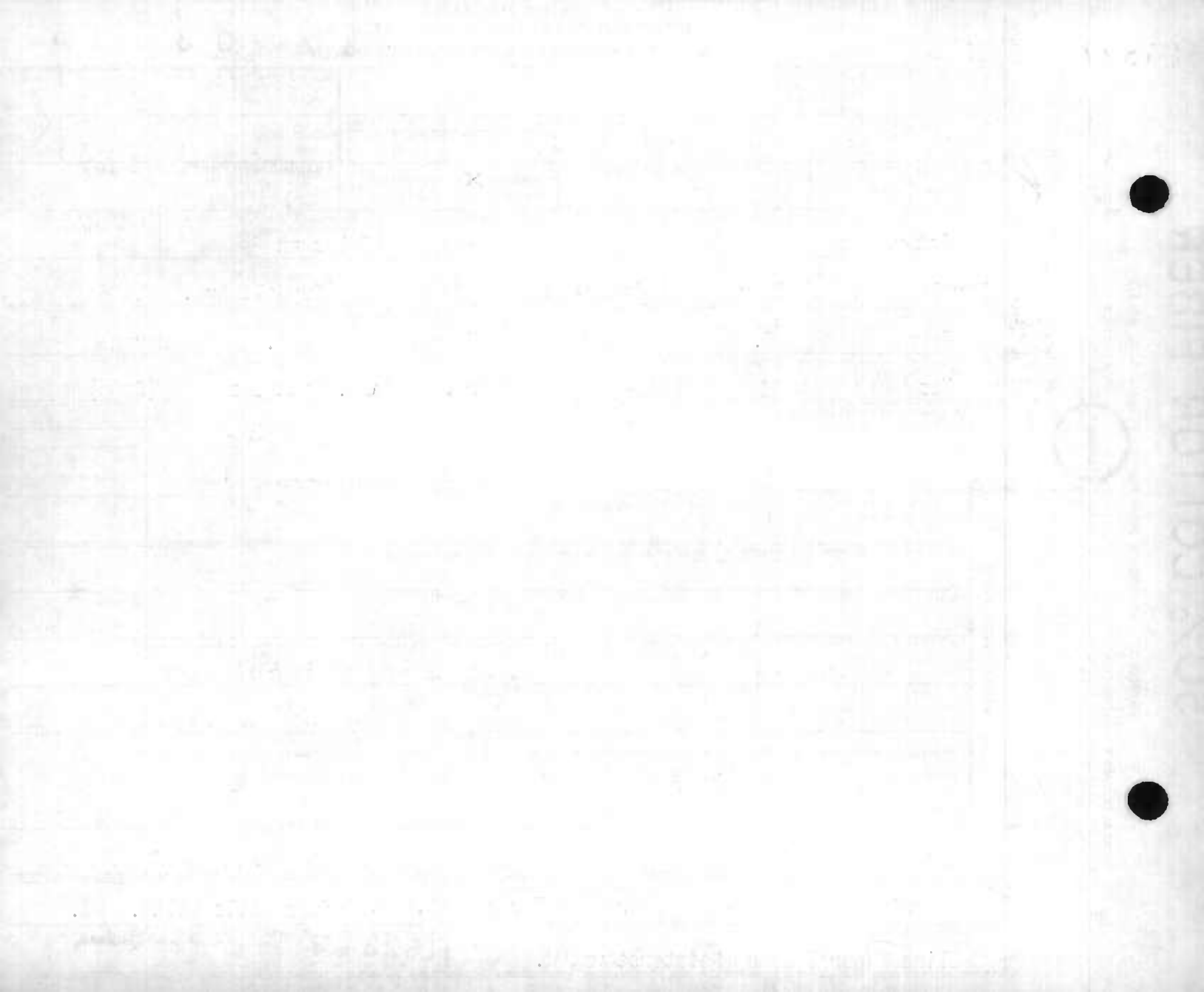
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
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DHMH - 17  
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please render the following papers. Page 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. Page 3 should be retained by the funeral director. IMPORTANT: If item 21 is marked or item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 03801	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>JULIA V. Matthews</b>				2a. DATE OF DEATH / MONTH DAY YEAR <b>2/14/87</b>				2b. HOUR <b>8:20 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-9-40</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. County</b> MD.					
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>STELLA MARIS HOSPICE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRAVEL CONSULTANT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SINGER TRAVEL AGENCY</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3801 CORNADO RD. MARYLAND</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>STEVEN SLOWE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BESSIE HOLLAND</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO.</b>		16b. SOCIAL SECURITY NO. <b>220-36-2317</b>		17. INFORMANT <b>MR. DONALD L. MATTHEWS</b> ADDRESS <b>3801 CORNADO ROAD BALTIMORE, MD. 21207</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Breast Ca (mets)</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>2/11/87</b> to <b>2/14/87</b> , that (I) (we) last saw the deceased alive on <b>2/14/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (daily) did not view the body after death.											
22b. SIGNATURE <b>Carla S. Alexander MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>2/14/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carla S. Alexander, M.D.</b>				22e. ADDRESS <b>Stella Maris Hospice Dulaney Valley Rd. - Towson, MD 21204</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2/18/1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARRISON FOREST VETERANS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MARYLAND</b>					
24. FUNERAL HOME <b>NUTTER &amp; SONS FUNERAL HOME, INC.</b> ADDRESS <b>2501 G.WYNN'S FALLS PKWY. BALTO. MD. 21216</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 18 1987</b>		25b. REGISTRAR'S SIGNATURE					

BP

Handwritten notes and scribbles at the top of the page, including the word "HILLMAN" and other illegible markings.

Large section of the page containing faint, mostly illegible handwritten text and markings, possibly bleed-through from the reverse side.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03808  
REG. NO.

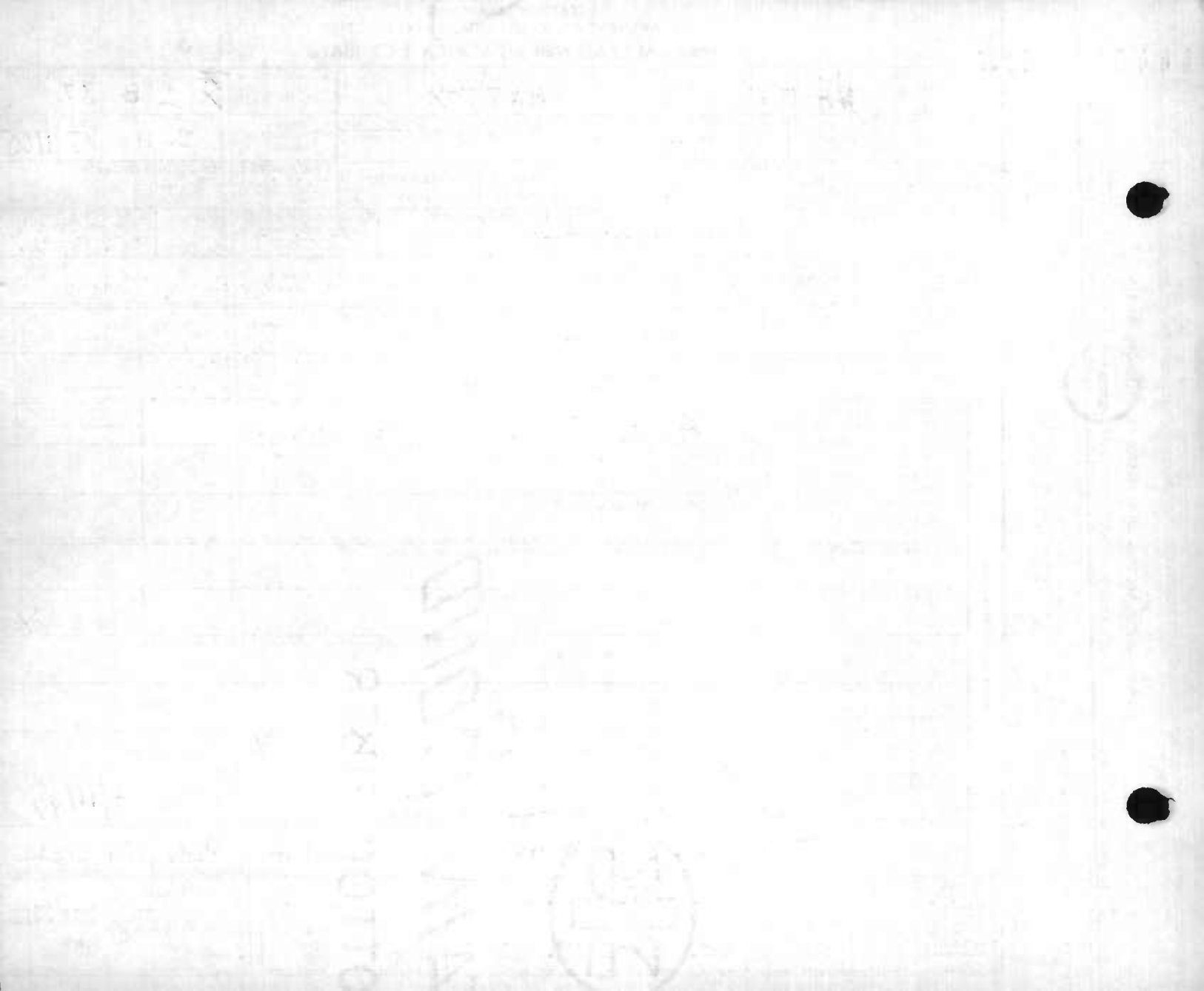
FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST INA (INA)		MIDDLE MAE	LAST MATTOX		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 2	DAY 8	YEAR 1987	2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5/11/1903		6. AGE (IN YEARS) LAST BIRTHDAY 83 YRS.	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 11 1987		2d. HOUR 1103A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 55 Northship Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.				
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland		12b. CITY Baltimore		12c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 55 Northship Rd. 21222				
14. FATHER'S NAME FIRST MIDDLE LAST Henry Brashears				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Green								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 230.09.8332A		17. INFORMANT M. Pauline Davis ADDRESS Rt. 1, Box 407A, Wildwood, Fla. 32785								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute intracerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>J. Crossan Olanov</u>		TITLE (SPECIFY) <u>Deputy</u>				MEDICAL EXAMINER		DATE SIGNED 2/11/87				
EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN OLANOV		ADDRESS 2112 Dundalk Ave., Balto., Md. 21222										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/15/1987		23c. NAME OF CEMETERY OR CREMATORY Yellow Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Summit North Carolina				
24. FUNERAL DIRECTOR Walter Brooks Bradley Inc. Dundalk Md. 21222						25a. DATE REC'D. BY REGISTRAR FEB 17 1987		25b. REGISTRAR'S SIGNATURE <u>W. Brooks Bradley</u>				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Anna Theresa Hatter McCarson			2a DATE OF DEATH MONTH DAY YEAR 02 17 87		2b HOUR 7:45 am
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR June 13 1916		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Towson	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Employment Security	12b KIND OF BUSINESS OR INDUSTRY State of Md.	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Maryland			13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Jeremiah J. Hatter			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa F. Hartman		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. - 216-10-0538		17 INFORMANT ADDRESS Joseph W. McCarson, 120 E. Timonium Rd. 21093	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 9289 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a DATE OF OPERATION 02/02/87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Occipital Hemmorrhage; Cerebral Hematoma		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Anil Uberoi		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Anil Uberoi, M.D.		22e ADDRESS G.B.M.C.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 2/20/87	23c NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Timonium Balto. Md.	
24 FUNERAL DIRECTOR NAME Martin D. Lawson, 10 W. Padonia Rd., 21093		25a DATE REC'D. BY REGISTRAR FEB 20 1987		25b REGISTRAR'S SIGNATURE Anil Uberoi	

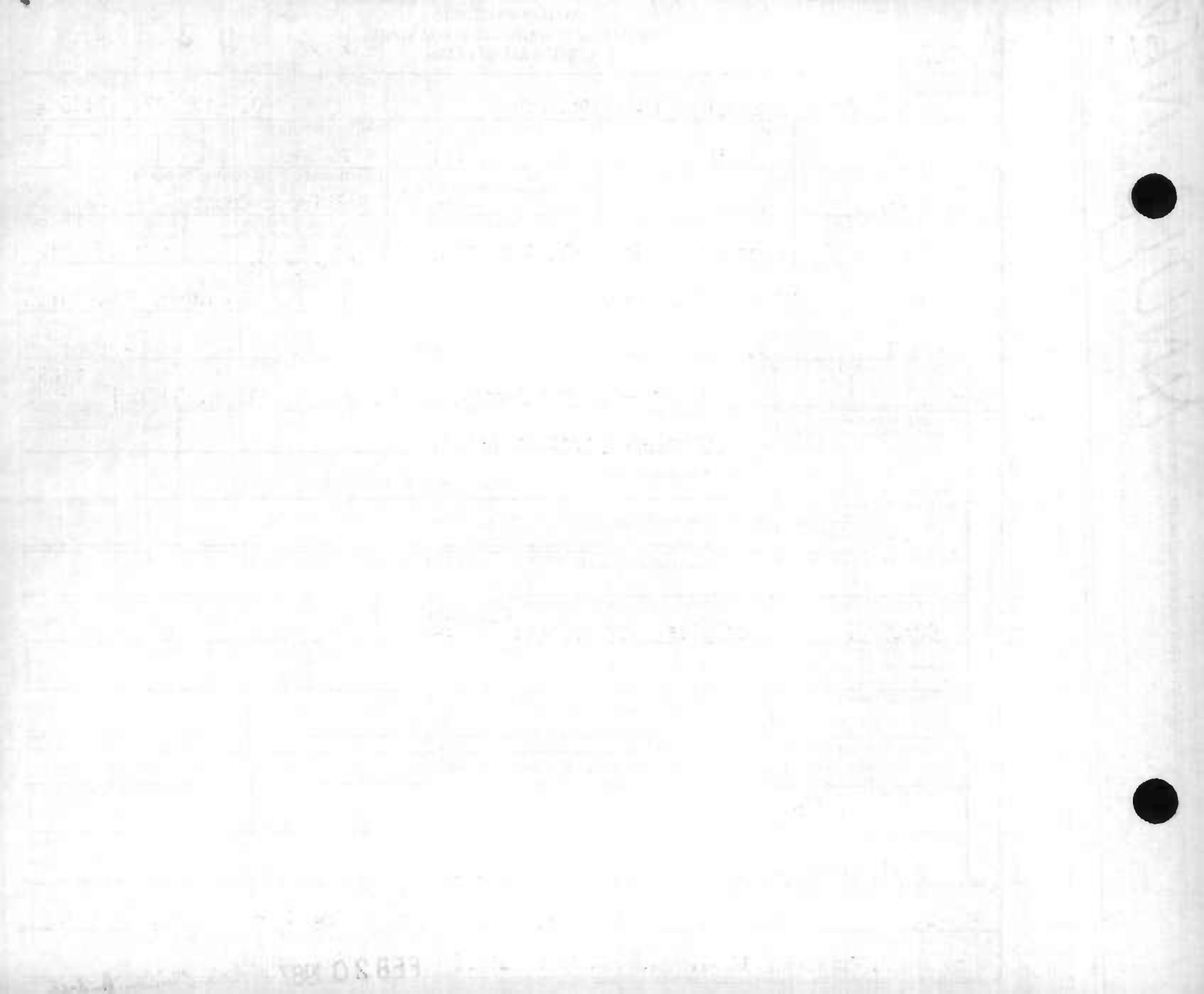
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the Medical Examiner shall be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the remaining pages to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANCIS <i>FRANCIS</i> L. <i>MCDORMAN</i>			2a. DATE OF DEATH MONTH DAY YEAR 2/19/87 Z 19 1987		2b. HOUR 11 08 PM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 02 18 8	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) M D	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPHS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney RETIRED		12b. KIND OF BUSINESS OR INDUSTRY Insurance
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE CITY BALTIMORE CITY		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS / ZIP CODE 5913 MEADOWWOOD RD 21212		
14. FATHER'S NAME FIRST MIDDLE LAST Alfred T. McDorman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora E. Crewe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 213 10 6529		17. INFORMANT ADDRESS Mrs. Elizabeth R. McDorman 5913 Meadowood Rd. 21212	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Pulmonary Embolism / Increased Intracranial Pressure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 hrs</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>INOPERABLE GRADE IV GLIOBLASTOMA OF BRAIN ASCD</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>10/20</u> , 19 <u>86</u> , to <u>2/19</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Charles O. Donovan III</i>		DEGREE MD		22c. DATE SIGNED 2/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES O. DONOVAN III MD		22e. ADDRESS 9 E. CHASE ST BALTIMORE, MD 21202			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/24/87	23c. NAME OF CEMETERY OR CREMATORY St. James Episcopal	23d. LOCATION CITY OR TOWN COUNTY STATE Monkton, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR FEB 25 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

BP

1031



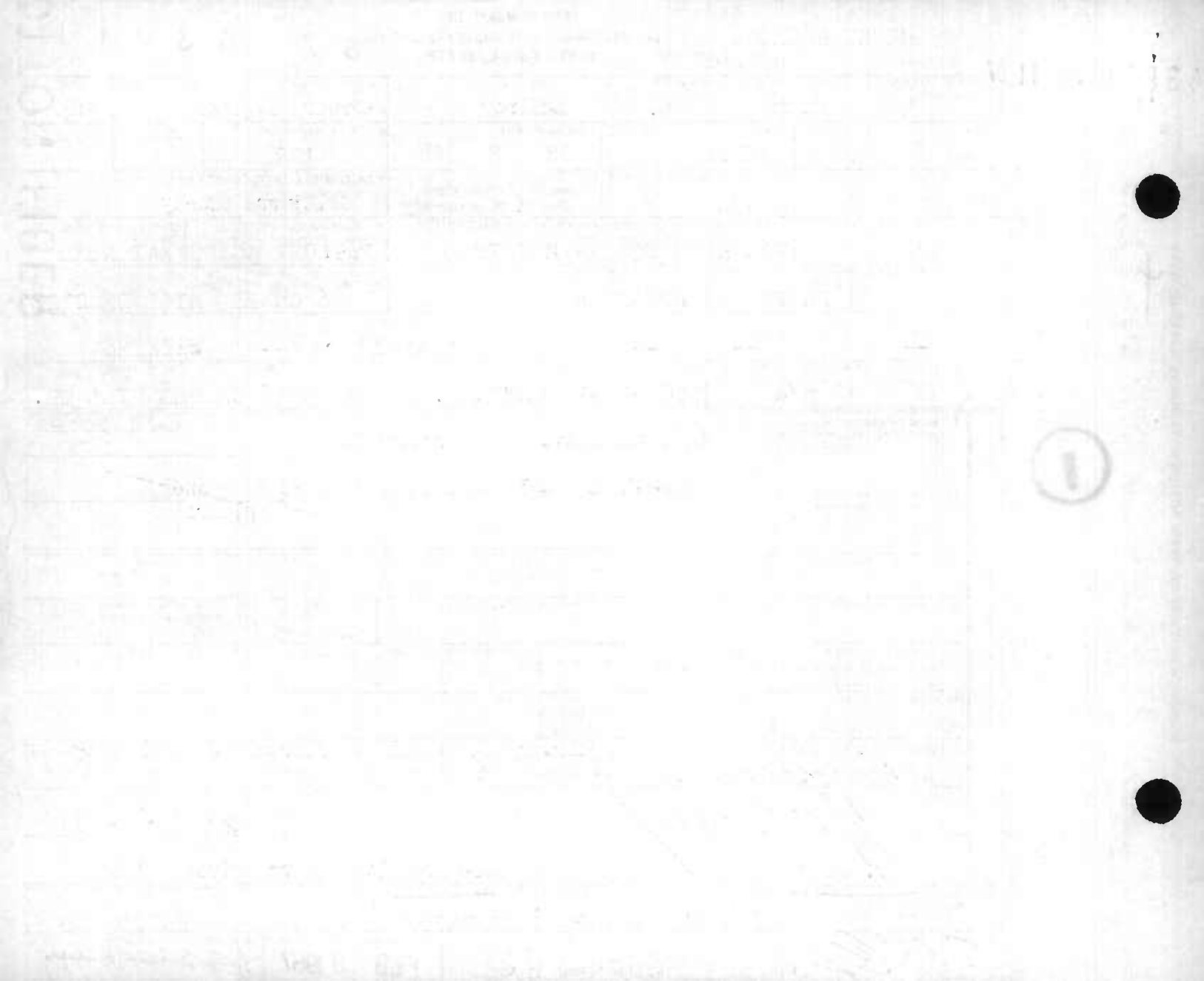
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach page 3 to pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR <b>HENRY EMERSON McELROY</b>									
1. DECEASED NAME (TYPE OR PRINT) Henry E. McElroy					2a. DATE OF DEATH MONTH DAY YEAR February 6, 1987		2b. HOUR 3:50 am		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 08 18 1884		6. AGE (IN YEARS LAST BIRTHDAY) 102 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FREIGHT AGENT		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN ROSEDALE					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1416 CHAPEL HILL DR 21237		
14. FATHER'S NAME FIRST MIDDLE LAST -- -- --					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH -- WATKINS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT ADDRESS ANNA M. MILES 1416 CHAPEL HILL DR.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left pneumonitis and bronchitis DUE TO, OR AS A CONSEQUENCE OF (b) Disseminated malignant tumor in left lung and pleura DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from February 4, 19 87, to February 6, 19 87, that (we) last saw the deceased alive on February 6, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.)									
22b. SIGNATURE <i>Samman</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 2.6.87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Samman				22e. ADDRESS 9000 Franklin Square Drive, 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/9/87		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO BALTO MD			
24. FUNERAL DIRECTOR <i>Samman</i>				25a. DATE REC'D. BY REGISTRAR FEB 9 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

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045108 FEB 26 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please enclose certificate in papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified for an autopsy.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 03812	
1. FOR STATE REGISTRAR					REG. NO.						
2. DECEASED NAME (TYPE OR PRINT) <b>MARGARET MARY MCKEOWN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>02 23 87</b>			2b. HOUR <b>8:07a M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>November 17, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Payroll Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE <b>5511 Woodlawn Rd. 21210</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leonard J. Curry</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Brown</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-10-4142</b>		17. INFORMANT <b>Mary Sheila Gill</b>		ADDRESS <b>Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b>  DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <b>GI BLEED</b>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>BREAST CA WITH LIVER AND BRAIN METS.</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>02/15</b> , 19 <b>87</b> , to <b>02/23</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>02/23</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Charles Emala MD</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>2/23/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES EMALA, M.D.</b>					22e. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/27/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto., Md. 21212</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 25 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Lia Davidson-Randall</b>				

WILSON, J. H.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. Medical examiner must be notified in one.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified in one.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) <b>KYLE</b>		FIRST -		MIDDLE -		LAST <b>McMILLION</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>02 19 87</b>		2b. HOUR <b>8:45 p</b>		M	
3. SEX <b>MALE</b> <del>Female</del>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 11 1987</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>9 days</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.							
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING (IFE)) -		12b. KIND OF BUSINESS OR INDUSTRY -							
13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>Balto.</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>10 Bohn Ct. 21237</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael McMILLION</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sharon Saynuk</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT ADDRESS <b>same</b> <b>Michael McMillion (father)</b> address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPOPLASTIC LEFT VENTRICLE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>02/11</b> , 19 <b>87</b> , to <b>02/19</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>02/19</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Virma V. Torres</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VIRMA V. TORRES, M.D.</b>		22e. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/21/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fullerton Md.</b>							
24. FUNERAL DIRECTOR NAME <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>9705 Belair Rd., Balto. Md. 21236</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 24 1987</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

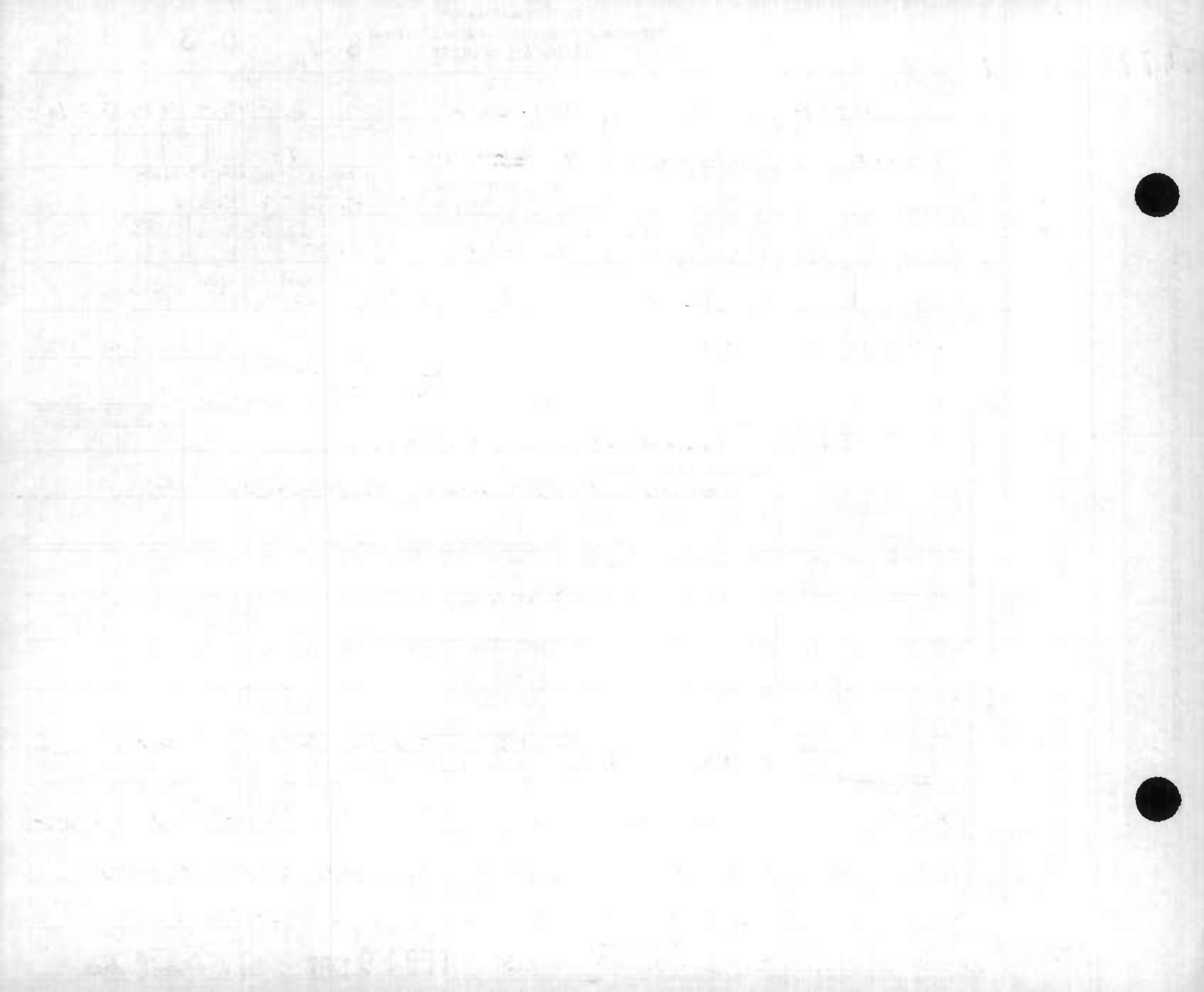
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 03814  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
T. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR	
ETTA		MERCUR		2-15-1987 22:10 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female	White	4-25-1908	28 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	USA		BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
RANDALLSTOWN	BALTIMORE COUNTY GEN. HOSP.		NURSE	MEDICINE	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MARYLAND		BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3501 ST. PAUL ST. #21218	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
BENJAMIN CLUSTER		FANNIE WHITMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT'S NAME AND ADDRESS			
NO		MRS. PEARL HYMAN 2412 BRAMBLETON RD. BALTO., MD 21209			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-13</u> , 19 <u>87</u> , to <u>2-15</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2-15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Allan J. Chiriac M.D.</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>2-15-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Allan J. Chiriac M.D.</u>		22e. ADDRESS <u>Balt. County General Hosp</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL	FEB. 17, 1987	BALTIMORE HEBREW	REISTERSTOWN BALTO. MD		
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE			
SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215		FEB 19 1987 <u>Julia Gordon-Randall</u>			

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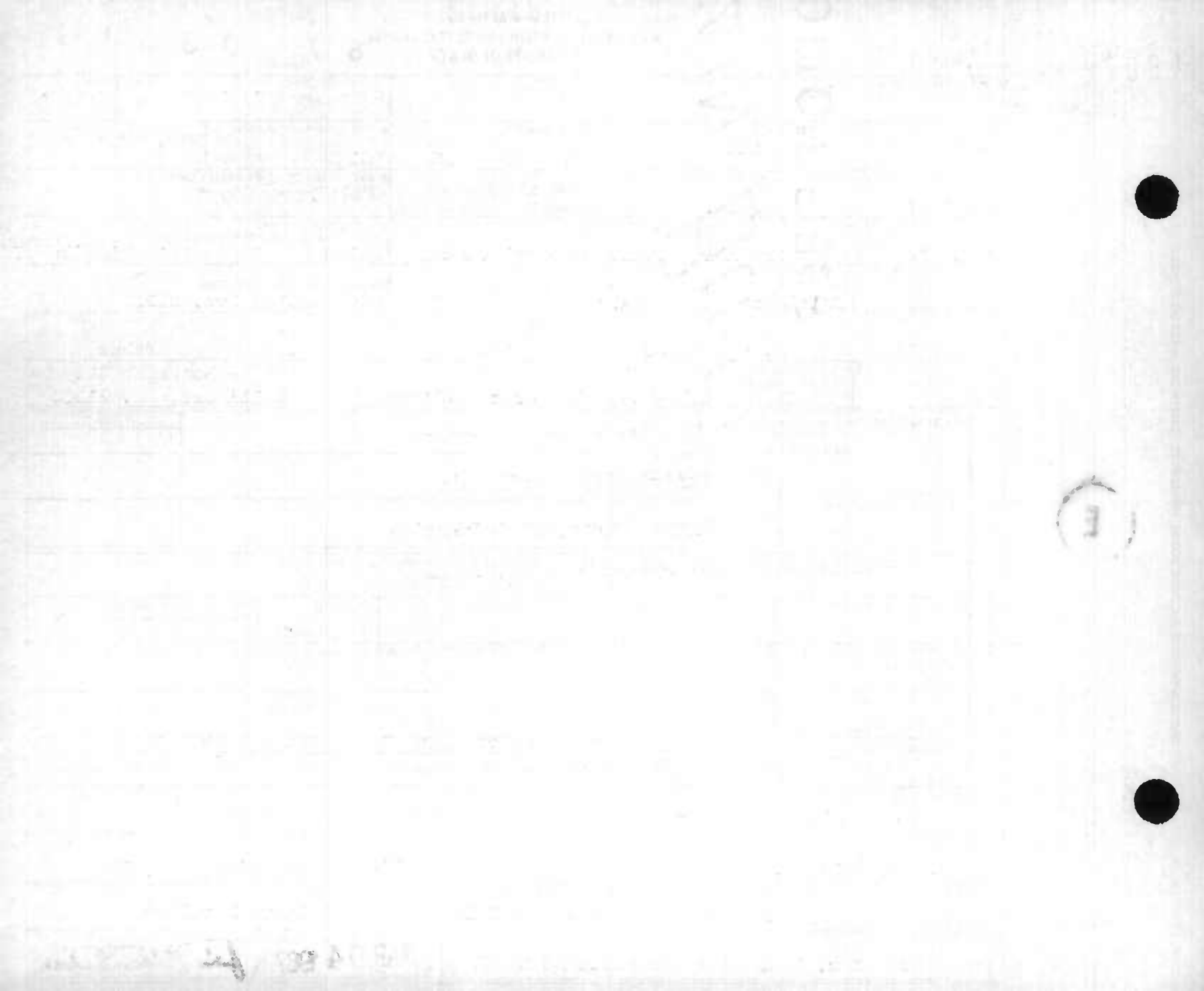


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please return carbon papers, Pages 1 and 2, should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 03815	
1. DECEASED NAME (TYPE OR PRINT) <b>William J. MEYER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>February 27, 1987</b>			2b. HOUR <b>5:38 A<sub>M</sub></b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 25 25</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rosedale</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B.C. Herman Plumbing Supp.</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Rosedale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8208 Analee Ave. 21237</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William J. Meyer</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary T. Arthur</b>				16. ADDRESS <b>6 Monhegan Ct. Baltimore, Md. 21236</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT <b>Joyce Ashburn</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ventricular fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute myocardial infarction</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Biventricular heart failure, bronchospasm</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>February 18, 1987</b> to <b>February 27, 1987</b> , that (I) (we) lost saw the deceased alive on <b>February 27, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>M. Leonidov M.D.</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. Leonidov, M.D.</b>						22e. ADDRESS <b>9000 Franklin Square Drive, 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-2-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck, Inc. 7922 Wise Ave Balto Md 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 04 1987</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) <i>Wanda L. Michaelis</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>2-27-87</i>		2b. HOUR <i>0900 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 28 34</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>52</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Randallstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore County General Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Administrative Asst.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Bank</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Reisterstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Densil Reed</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Addie Nicholson</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>			
16b. SOCIAL SECURITY NO. <i>234-54-2473</i>		17. INFORMANT ADDRESS <i>Teresa Crouse, 1720 Fridinger Mill Road</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Stroke</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>2-23-87</i> to <i>2-27-87</i> that (I) (we) lost saw the deceased alive on <i>2-27-87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>L. Girgis</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2-27-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RAAFAT GIRGIS</i>		22e. ADDRESS <i>Baltimore County Hosp.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/2/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Hubbard Funeral Home, Inc., 4107 Wilkens Ave. 21229</i>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Julia Tilden</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the funeral director. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 03817	
1. DECEASED NAME (TYPE OR PRINT) Winfield MIDDENDORF					2a. DATE OF DEATH MONTH DAY YEAR February 24, 1987			2b. HOUR 2:30a. M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 3, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Motor Freight Mech.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5510 Cedella Avenue 21206			
14. FATHER'S NAME FIRST MIDDLE LAST Harry Middendorf					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Eisenrode						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-03-0209		17. INFORMANT ADDRESS Mrs. Jeanette Aversa 5509 Daybreak Terr.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest; Malignant Arrhythmias DUE TO OR AS A CONSEQUENCE OF (b) Recent Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Congestive heart failure, Chronic Obstructive Pulmonary Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from February 8, 1987, to February 24, 1987, X saw the deceased alive on February 24, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. X X X X											
22b. SIGNATURE Michael Leonidov, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-24-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 9000 Franklin Square Drive, 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 27, 1987		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR FEB 24 1987		25b. REGISTRAR'S SIGNATURE					

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044426 FEB 19 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 03818  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John C. Miminger, Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 16 87</b>			2b. HOUR <b>0307<sup>M</sup></b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 12 68</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>18</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County Gen. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) _____	
12b. KIND OF BUSINESS OR INDUSTRY _____		13a. STREET ADDRESS / ZIP CODE <b>5632 Bartholow Road 21784</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Clayton Miminger, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nancy Jackson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>William &amp; Mae Smith Sykesville, MD 21784</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardio respiratory arrest**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**10 MINUTE**Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **SEIZURE DISORDER****10 MINUTES**

DUE TO, OR AS A CONSEQUENCE OF

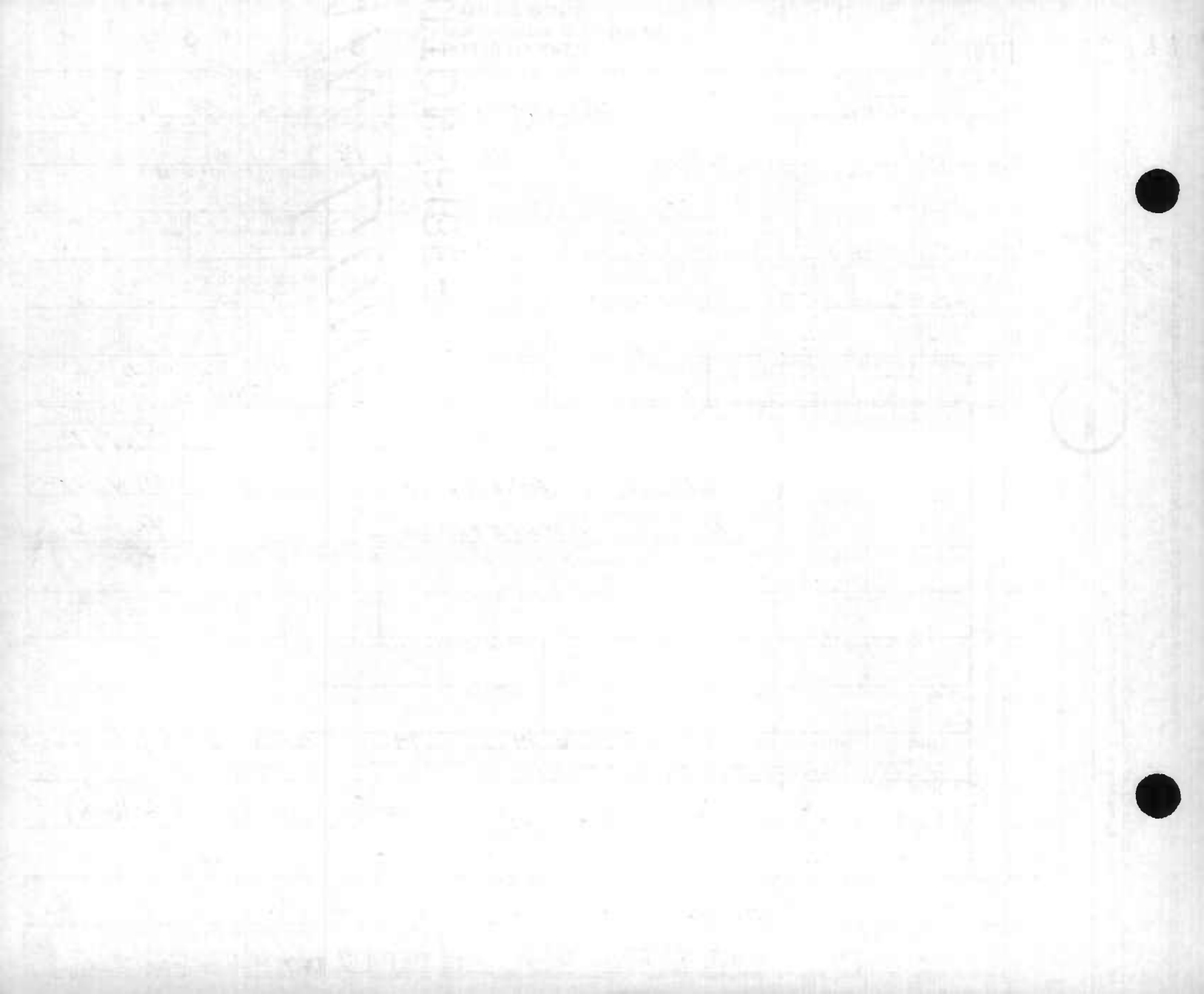
**CONGENITAL HYDROCEPHALUS -****YEARS.**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**Congenital Hydrocephalus**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6-19</b> , 19 <b>74</b> , to <b>2-16</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dr. Naci Buyukansal</b>				22c. DATE SIGNED <b>2-16-87</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Naci Buyukansal, M.D.</b>	
22e. ADDRESS <b>Route 32 Eldersburg, Maryland 21784</b>				22f. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>02-19-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Johnsville Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Carroll MD</b>	
24. FUNERAL DIRECTOR NAME <b>HAIGHT FUNERAL HOME SYKESVILLE, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 17 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Anderson-Pandey</b>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8703819  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LORETTA HELEN MOMJIAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 12, 1987</b>		2b. HOUR <b>7:00 AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>January 8, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH'S HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Towson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Cadden</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ann Deveney</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-44-9921</b>		17. INFORMANT ADDRESS <b>Ann L. Kelleher Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart failure.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Adel S. El-Kennawy MD</b>				22c. DATE SIGNED <b>2-12-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Adel S. El-Kennawy</b>				22e. ADDRESS <b>STH.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>2/17/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc.</b>		ADDRESS <b>6500 York Rd. Balto., Md. 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 13 1987</b>	
25b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low Registrar certifies that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The placemarker and carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, other traumatic event, the medical examiner must be notified at once.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
<div style="text-align: right;">87 03820</div> <div style="text-align: center;">REG. NO.</div>											
1. DECEASED NAME (TYPE OR PRINT) Lillie Marie MOORE						2a. DATE OF DEATH MONTH DAY YEAR February 27, 1987			2b. HOUR a m 7:16 a		
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2-24-25		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. Hos.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H/W			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN ESSEX						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 931 SANDLEWOOD RD. BAL. 21221		
14. FATHER'S NAME FIRST MIDDLE LAST JESSIE MOORE						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSIE MCKNIGHT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO 272 24 9878		17. INFORMANT ADDRESS LINDA HALL 931 SANDLEWOOD RD - 21221					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>— NONE —</u>											
19a. DATE OF OPERATION —				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2-1-</u> 19 <u>87</u> to <u>2-14</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2-26-</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Shankar L. Gupta</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-27-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHANKER L. GUPTA				22e. ADDRESS 1802 EASTERN AVE BALTIMORE, MD 21231							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE MAR. 2 1987		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR NAME LILLY & ZEILER, INC.				ADDRESS 700 S. CONKLING ST.		25a. DATE REC'D. BY REGISTRAR MAR 03 1987		25b. REGISTRAR'S SIGNATURE A. J. Anderson-Randall			

MEDICAL CERTIFICATION

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

046279 MAR 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8703821

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |
| Herbert E. Muenze   |  |  |  | February 28, 1987  |  | 9 PM  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  |
| Male  | White  | June 26, 1939  |  | 47   |  | YRS. MONTHS DAYS HRS. MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| Maryland  | USA  |  |  | Baltimore County MD  |  |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Dundalk   | 8237 N. Boundary Road 21222  |  |  | Pressman   |  | US Treasury   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13b. STREET ADDRESS / ZIP CODE   |  |   |  |
| 13a. STATE CITY COUNTY Maryland Baltimore Dundalk   |  |  |  | 13b. 8237 N. Boundary Road 21222   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |
| Paul W. Muenze  |  | Beatrice Sands   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |
| No  |  | 216-34-8899  |  | Frances J. Muenze 8237 N. Boundary Rd.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Sepsis</u>   |  |  |  |  |  |   | 1 day  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Liver failure</u>   |  |  |  |  |  |   | 3 days                                       |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chelation colic cancer</u>  |  |  |  |  |  |   | 2 1/2 years                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
|   |  | P.M. 19  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
|   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/15/87</u> to <u>2/4/87</u> , that (I) (we) last saw the deceased alive on <u>1/15/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE <u>M. Ruck</u>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <u>3/1/87</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MILHARL RUCKER</u>   |  | 22e. ADDRESS <u>7740 Eaden Ave BALT MD 21224</u>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| Burial  |  | 3-4-87   |  | Sacred Heart of Jesus  |  | Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222  |  | MAR 05 1987  |  | <u>[Signature]</u>   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DEPT. NOTTINGHAM

CHIEF CLERK

10-10-10

044540 FEB 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 03822

|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THEODORE S MULLANEY   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 14 87                         |   |  | 2b. HOUR<br>1:50 P.M.  |   |  |  |
| 3. SEX<br>M  |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 21 46  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>40 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO County MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO Co. Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Investigator   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Greenwood Re  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br>1266 MERIDENE DRIVE Covery 21239   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Theodore John Mullaney   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen M. Vogt  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-50-2542  |  | 17. INFORMANT<br>ADDRESS<br>Helen M. Lapachinsky-1266 Meridene Dr.-21239   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MASSIVE GASTROINTESTINAL BLEEDING<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) HEPATIC CIRRHOSIS; ANASARCA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/14 19 87 to 2/14 19 87, that (I) (we) last saw the deceased alive on 2/14 19 87, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br>L. Ceballos, M.D.  |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>2/14/87  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LILIA CEBALLOS  |  |  | 22e. ADDRESS<br>ST. JOSEPH HOSPITAL                                    |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  |  | 23b. DATE<br>2-17-87   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount Cemetery                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John C. Miller, Inc.-6415 Belair Rd.-21206   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 17 1987                                   |  | 25b. REGISTRAR'S SIGNATURE<br>Gordon R. Rude                      |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, if state-issued carbon papers, pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |   |   |  |  |  |
|--|--|--|---|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   | 87 03823<br>REG. NO.  |   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>THOMAS J. MURPHY  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>02 16 87  |   |  | 2b. HOUR<br>5:02A M  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>01 24 24   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CNTY. MD.                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO. CNTY.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL 7620 YORK RD 21204 |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Tax Collector                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>St. of Md.  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTO.  |   | 13c. CITY OR TOWN<br>BALTO CNTY   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>6652 LOCH HILL RD 21239  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Lawrence Murphy   |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Loretta Slaughter  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WWII   |   | 17. INFORMANT ADDRESS<br>M. Murphy 10302 Sunny Lake Place 21030   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>15 yr</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>acute</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>72</u> to 19 <u>87</u> , that (I) (we) lost <u>1/19</u> <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <u>not</u> view the body after death.   |  |  |   |   |   |   |  |  |  |
| 22b. SIGNATURE <u>David A. Oursler</u>   |  |  |   |   | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED <u>2/16/87</u>                                    |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David A. Oursler  |  |  |   |   | 22e. ADDRESS<br>7401 Osler Drive 21204  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  |  | 23b. DATE<br>2-17-87  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount Crematory  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Mitchell-Wiedefeld Home 6500 York Road 21212  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 19 1987  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rudolph</u>        |  |  |

BP

THE UNIVERSITY OF CHICAGO  
LIBRARY  
1215 EAST 58TH STREET  
CHICAGO, ILL. 60637

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
DATE: [illegible]  
[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a letter or report.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers. Pages 1 and 2 should be kept within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical certificate must be completed and signed by a physician.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 87   |  | 03824   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Rose Irene Myers  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2-4-87  |  | 2b. HOUR<br>M   |  |   |  |
| 3. SEX<br>female   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2-18-16  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |  | 7. NUMBER 1 YEAR<br>MONTHS DAYS   |  |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., MD  |  | 7d. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                     |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                        |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>Balto. Co.  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>6202 Marglenn Ave. Balto. 21206   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Anthony Tamburo   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Grace Stein  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>215-07-2560  |  | 17. INFORMANT ADDRESS<br>James R. Myers, 6202 Marglenn Ave. 21206   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per item for (a), (b) and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest - ASCVD -</u><br>DUE TO, OR AS A COMPLICATION OF, <u>Unstable Angina + CHF</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>2 Polymyalgia Rheumatica</u><br>(c) <u>2 Polymyalgia Rheumatica</u> |  |  |  | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (b) NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(IF HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22. I certify that (I) (the hospital) attended the deceased from 2/2/87 19 to 2/4/87 19 that (I) (we) last saw the deceased alive on 2/3/87 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.  |  |  |  |   |  |   |  |   |  |
| 23a. SIGNATURE<br>DONALD W. MILLER MD  |  | DEGREE   |  | 23b. ADDRESS<br>3099 EVERGREEN AVE BALTO MD   |  |   |  | 23c. DATE SIGNED<br>2/4/87  |  |
| 23d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 23e. ADDRESS   |  | 23f. DATE REC'D. BY REGISTRAR   |  | 23g. REGISTRAR'S SIGNATURE<br>Julia Henderson-Randall   |  |   |  |
| 23h. BURIAL, CREMATION, REMOVAL<br>Cremation   |  | 23i. DATE<br>2-5-87  |  | 23j. NAME OF CEMETERY OR CREMATORY<br>Greenmount Crematory  |  | 23k. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. MD   |  | 23l. FUNERAL DIRECTOR<br>John C. Miller, In.c, 6415 Belair Rd. 21206  |  |

3

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |                                      |   |  |  |  |   |  |
|--|--|--|--------------------------------------|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Adele</b>  |  |  | FIRST MIDDLE LAST<br><b>Vaiditch</b> |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 18 87</b>  |  | 2b. HOUR<br><b>11:30 PM</b>   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 28 08</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>FRANCE</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Nursing Center Randallstown</b> |                                      |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                     |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |                                      | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS / ZIP CODE<br><b>3016 FALLSTAFF MANOR CT. 21209</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |  |                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA UNKNOWN</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED SERVICES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |                                      | 16b. SOCIAL SECURITY NO.<br><b>082-10-2574</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. JOYCE LEVINSON 9 POMONA NORTH, APT. 10 (21208)</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ASCD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)                |  |  |                                      |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b>           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>acute Pericardium, Diabetes mellitus</b>   |  |  |                                      |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>10/30/86 2119/87</b>  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/30/87</b> 19 <b>87</b> , to <b>2/19/87</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2/30/87</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |                                      |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Joseph Shear</b>  |  |  |                                      | DEGREE<br><b>PHYSICIAN</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/19/87</b>                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH SHEAR, M.D.</b>   |  |  |                                      | 22e. ADDRESS<br><b>6715 PARK HEIGHTS AVE. BALTO., MD</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2/22/87</b>  |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON CEMETERY</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |                                      |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>FEB 25 1987</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julie Leachman-Radner</b>              |  |

RECEIVED

U.S. DEPARTMENT OF THE ARMY  
WASHINGTON, D.C.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03826

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |   |  |
|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Charles G. NALBANDIAN</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 16 87</b>   |   | 2b. HOUR<br><b>8<sup>15</sup> PM</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 8, 1907</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS                               |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MASS.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>            |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>QUALITY CONTROL</b>      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MARTIN'S</b>                           |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>PARKVILLE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>8515 OLD HARFORD ROAD 21234</b>           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SARKIS NALBANDIAN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARGARET Melikian</b>   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>048 014308</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>FAMILY RECORDS</b>                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-1</b> , 19 <b>86</b> , to <b>2-19</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2-12</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |
| 22b. SIGNATURE<br><b>Carla S. Alexander M.D.</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |   | 22c. DATE SIGNED   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARLA S. ALEXANDER M.D.</b>   |  | 22e. ADDRESS<br><b>2300 Dulany Valley Rd Towson Md 21204</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>2-19-1987</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY ROSSNER</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>        |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS CHAPEL OF MEMORIES HARFORD</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 18 1987</b>   |   |  |
|   |  | 25b. REGISTRAR'S SIGNATURE  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove certain pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



042853 FEB -

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

LAST

JAMES

NALL

2. DATE OF DEATH

MONTH

DAY

YEAR

26 HOUR

2-1-87

5:30 P.M.

3. SEX

MALE

4. RACE

WHITE

5. DATE OF BIRTH

MONTH

DAY

YEAR

08-05-08

6. AGE (IN YEARS LAST BIRTHDAY)

78

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

KENTUCKY

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE COUNTY, MD.

10. CITY OR TOWN OF DEATH

TOWSON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

MANOR CARE - TOWSON

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

ASSIST. COMPTROLLER RAILROAD

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

FLORIDA

13b. COUNTY

33519

13c. CITY OR TOWN

CLEARWATER

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

2855 GULF TO BAY BLVD. 33519

14. FATHER'S NAME

JAMES

ROSCOE

NALL

15. MOTHER'S MAIDEN NAME

MAUDE

ALICE

VIERS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

-----

17. INFORMANT

704-03-6986

17. INFORMANT

GORDON C. NALL 4813 VICKY RD. 21236

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF

(b)

End Stage COPD

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Anginal. Ventricular arrhythmias

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY  
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

22a. I certify that (I) (this hospital) attended the deceased from 1/28, 19 87, to 2/1, 19 87, that (I) (we) last saw the deceased alive on 2/1, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

Sireesh K. Tripurani

M.D. ATTENDING PHYSICIAN

MEDICAL DIRECTOR ☒STAFF PHYSICIAN ☐

2/2/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

SIREESH K TRIPURANI

22e. ADDRESS

Good Samaritan Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

CREMATION

23b. DATE

FEB. 3, '87

23c. NAME OF CEMETERY OR CREMATORY

GREEN MOUNT CEMETERY BALTIMORE, MARYLAND

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.

25a. DATE REC'D. BY REGISTRAR

FEB 03 1987

25b. REGISTRAR'S SIGNATURE

Julia Tindon-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

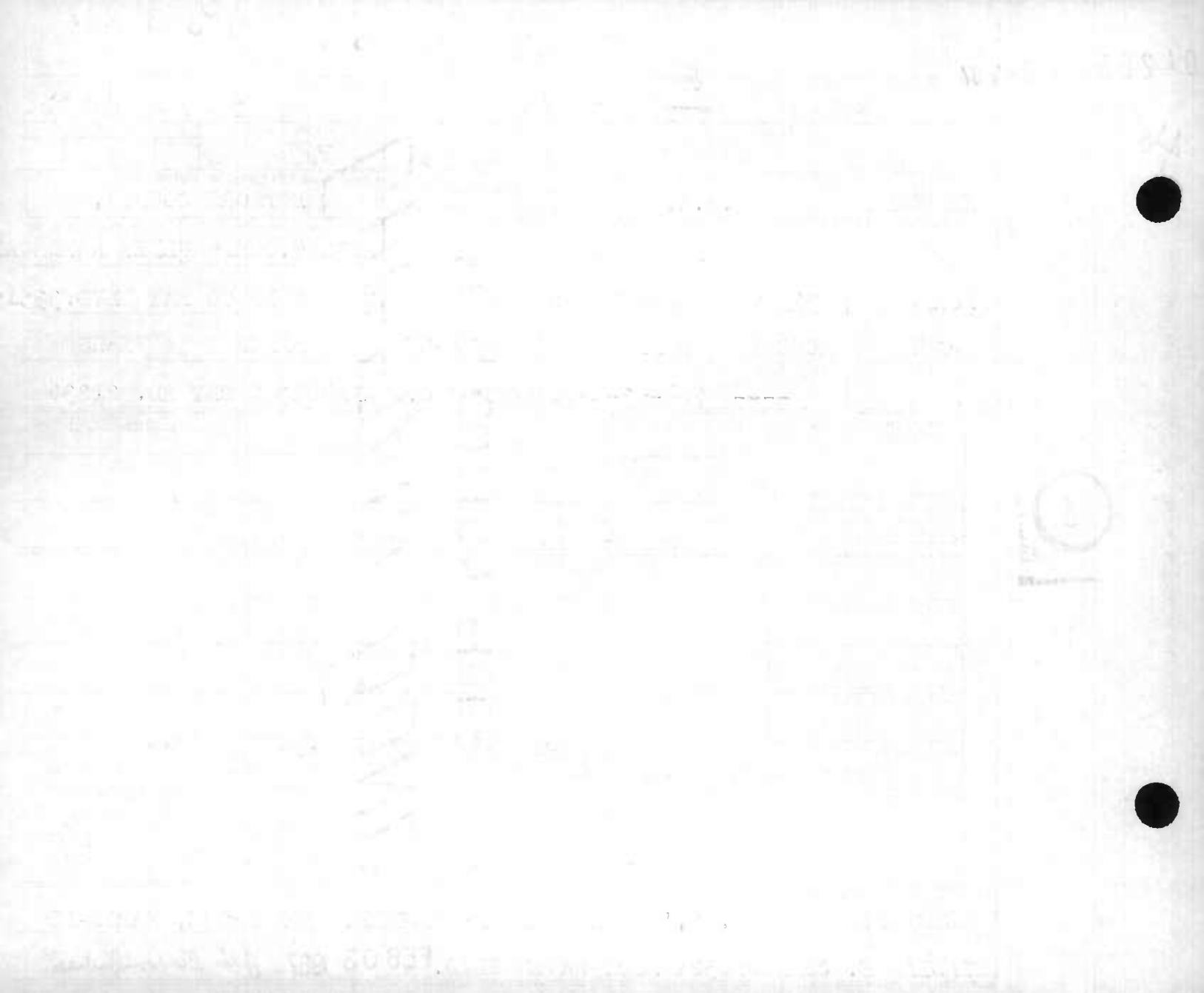
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose to the Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, have any injury, let other significant event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

17 FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARGARET L. NECKER   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 27 87 |   |  | 2b. HOUR<br>12:45 PM  |   |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 2 1902  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.                                  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO COUNTY MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSP. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>AT HOME |   |
| 13a. STATE<br>MARYLAND   |  |   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES C. SCHERRER  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA BOEL  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   |  | 16b. SOCIAL SECURITY NO.<br>216076415   |  | 17. INFORMANT<br>FAMILY RECORDS   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PERFORATED DUODENAL ULCER<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24-48 HR.   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>PSEUDOMEMBRANOUS PROCTO-COLITIS; MULTIFOCAL BRONCHOPNEUMONIA.  |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION<br>2/14/87  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>RIGHT HIP FRAX.   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/13/87, 19 to 2/27/87, 19, that (I) (we) last saw the deceased alive on 2/27/87, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br>JAMES W. EAGAN, JR. M.D.   |  |   |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 22c. DATE SIGNED<br>2/27/87   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   |  | 23b. DATE<br>MARCH 2, 1987  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEM.                         |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PARKVILLE BALTO. MD.   |  |   |  | 23e. NAME OF REGISTRAR<br>8800 RO.  |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>EVANS CHAPEL OF MEMORIES HARFORD   |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br>MAR 05 1987  |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

A. S. ... 789 30 24

045102 FEB 26 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then it should be placed in the envelope and 2 copies of the certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 7 0 3 8 2 9  |  |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br>Elizabeth Anne Nelker  |  |  |  | MONTH DAY YEAR<br>2/20/87  |  |
| 3. SEX<br>F   |  | 4. RACE<br>W   |  | 2b. HOUR<br>7P M   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 6, 1895  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                     |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 10. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                   |  |
| 11. CITY OR TOWN OF DEATH<br>Towson, Md.  |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Stella Maris Hospice |  | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker        |  |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>14a. STATE<br>Md.  |  | 14b. COUNTY<br>Baltimore   |  | 14c. CITY OR TOWN<br>Baltimore   |  |
| 15. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John L. Dorsch  |  | 16. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie O'Neill   |  | 17. STREET ADDRESS / ZIP CODE<br>522 Walker Ave. 21212                           |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 18b. SOCIAL SECURITY NO.<br>220 36 4390  |  | 19. INFORMANT ADDRESS<br>Blvd. -04<br>Mr. Charles F. Nelker, Jr. 8113 Loch Raven |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 7</u> , 19 <u>85</u> , to <u>Feb 20</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Feb 13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.                            |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Ebrahim Ipakchi, M.D.</u>  |  |  |  | 22c. DATES SIGNED<br>2/20/87   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ebrahim Ipakchi, M.D.  |  |  |  | 22e. ADDRESS<br>Stella Maris Hospice<br>2300 Pulaneg Valley Rd. Towson, Md.      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>2/25/87   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEFELD HOME, INC.   |  | 24b. ADDRESS<br>6500 York Rd.  |  | 24c. DATE REC'D. BY REGISTRAR<br>FEB 25 1987                                     |  |
| 24d. REGISTRAR'S SIGNATURE<br>Julia Tindon-Rudner   |  |  |  |  |  |

II-10-1987



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045206 FEB 26 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits are required by law for the removal of the body from the place of death to the place of burial, cremation, or other final disposition. The permit must be obtained from the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. If item 21 is marked or item 18 shows any injury, an official report must be filed with the State Dept. of Health and Mental Hygiene.

|  |  |   |  |  |   |  |  |   |  |  |  |                   |  |
|--|--|---|--|--|---|--|--|---|--|--|--|-------------------|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |   |  |  |   |  | 8 7 0 3 8 3 0                                      |  |                   |  |
| 1- FOR STATE REGISTRAR AKA Harry Alford Neff   |  |   |  |  |   |  |  |   |  | CERTIFICATE OF DEATH                               |  |                   |  |
| 2a. DECEASED NAME FIRST MIDDLE LAST Harry Alfred NEFF  |  |   |  |  |   |  |  |   |  | 2b. DATE OF DEATH MONTH DAY YEAR February 24, 1987 |  | 7b. HOUR 4:55 a M |  |
| 3. SEX Male  |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 31, 1909  |   | 6. AGE (IN YEARS LAST BIRTHDAY) 78   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN.                         |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Penna.   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.                                    |  |   |  |  |  |                   |  |
| 10. CITY OR TOWN OF DEATH Rossville 21237  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Franklin Sq. Hospital |  |  |   |  |  | 12a. USUAL OCCUPATION (LAST ONE BEFORE DEATH OR WORKING LIFE) Machinist   |  | 12b. KIND OF BUSINESS OR INDUSTRY Martin Co.       |  |                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |   |  |  |   |  |  |  |                   |  |
| 13a. STATE Maryland  |  | 13b. COUNTY Baltimore   |  | 13c. CITY OR TOWN Middle River   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE 318 Harding Ave. 21220   |  |  |  |                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Neff   |  |   |  |  | 15. MOTHER'S MAIDEN NAME MIDDLE LAST Mable Clippinger |  |  |   |  |  |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. -  |  | 17. INFORMANT Daisy Mary Neff, Wife  |   | ADDRESS Same   |  |   |  |  |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic and Hypertensive Cardiac Disease |  |   |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Gastrointestinal Bleeding and Chronic Obstructive Airway Emphysema   |  |   |  |  |   |  |  |   |  |  |  |                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |   |  |  |  |                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)           |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |  |  |                   |  |
| 22a. I certify that XX (this hospital) attended the deceased from February 10, 19 87, to February 24, 19 87, that X (we) last saw the deceased alive on February 24, 19 87, and that in (my) view the body after death.  |  |   |  |  |   |  |  |   |  |  |  |                   |  |
| 22b. SIGNATURE M. H. Elnahal, M.D.   |  | DEGREE M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |   | 22c. DATE SIGNED 2/24/87   |  |   |  |  |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. H. Elnahal, M.D.  |  | 22e. ADDRESS 9000 Franklin Square Dr., 21237                                  |  |  |   |  |  |   |  |  |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL Burial   |  | 23b. DATE 2/26/87   |  | 23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery  |   | 23d. LOCATION Shippensburg, Pa.  |  | STATE   |  |  |  |                   |  |
| 24. FUNERAL DIRECTOR Bruzdinski Funeral Home PA 1407 Old Eastern Ave   |  | 25. DATE REC'D BY REGISTRAR FEB 25 1987                                       |  | REGISTRAR'S SIGNATURE  |   |  |  |   |  |  |  |                   |  |

MEDICAL CERTIFICATION

AKA VERNY LLOYD BELL

white male  
DOB: 12-11-1909  
USA

on white 12537 Franklin St. Hospital  
Baltimore  
314 Harding Ave. 21220  
X  
Baltimore

DOB: 12-11-1909



21220-3  
Baltimore  
314 Harding Ave.  
Baltimore

BP

DHMM - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low resistance of the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   | REG. NO.   |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Sarah Edna NESBIT  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 2, 1987   |  | 2b. HOUR<br>10:00pm   |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 20 1892  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pa.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |   |
| 10. CITY OR TOWN OF DEATH<br>Rossville   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |  |   |
| 13a. STATE<br>Md.  | 13b. COUNTY<br>Balto.   | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>4010 C Marjeff Place 21236                         |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Schrivver  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>unknown  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |   | 16b. SOCIAL SECURITY NO.<br>214-74-3450   |   | 17. INFORMANT ADDRESS<br>Robert Nesbit 902 N. Marlyn Ave. 21221                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arteriosclerotic Cardiovascular Disease with Angina<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Hypertension with previous Myocardial Infarction |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)    |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from January 28, 1987, to February 2, 1987, that (we) last saw the deceased alive on February 2, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                    |   |   |   |  |   |
| 22b. SIGNATURE<br>R. S. Miranda, M.D.  |   | DEGREE  |   | 22c. DATE SIGNED<br>02/02/87   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. S. Miranda, M.D.   |   | 22e. ADDRESS<br>9000 Franklin Sq. Dr., 21237  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>2/5/87   | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Connelly Funeral Home  |   |   | ADDRESS<br>300 Mace Ave. 21221  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 4 1987   |
|  |   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia D. R. R. R.   |  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the physician who attended the deceased within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 2 and 3 and return them to the funeral director. Card 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |   |  |  |
|--|--|---|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | 8703832<br>REG. NO.  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Elsie Neuschaefer</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2- 2 9 87</b>                       |  |   | 2b. HOUR<br><b>10<sup>AM</sup></b>                               |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct. 29 1901</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS   |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                          |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Eastpoint</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Eastpoint Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Lever Bros.</b>          |   | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |
| 13a. STATE<br><b>md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>7209 Woodrow Ave. 21224</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William J. Mister</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Virginia Webster</b> |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>212-74-7558</b>  |  | 17. INFORMANT ADDRESS<br><b>Norman Mister 3041 Ebbitide Drive 21040</b>   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>DEMENTIA + COMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE <b>[Signature]</b> DEGREE <b>MD</b>   |  |   |  |   | 22c. DATE SIGNED<br><b>2. 10. 87</b>                                       |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>I. A. GROW</b>   |  |   |  |   | 22e. ADDRESS<br><b>223 E. Blvd BALTO md 21221</b>                          |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/11/87</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Essex Baltimore Md.</b>                        |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Connelly Funeral Home</b>  |  |   |  |   | 25. DATE RECEIVED BY REGISTRAR<br><b>FEB 13 1987</b>                       |  |   |  |  |
| ADDRESS<br><b>300 Mace Ave. 21221</b>  |  |   |  |   | 26. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                            |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner will be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 3 8 3 3  
REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |   |  |  |
|--|--|---|--|--|
| 1. DECEASED NAME<br>FIRST <u>BETTY</u> MIDDLE <u>JEAN</u> LAST <u>NEWMAN</u>   |  | 2a. DATE OF DEATH MONTH <u>2</u> DAY <u>10</u> YEAR <u>87</u>   |  | 2b. HOUR <u>12</u> P.M.  |
| 3. SEX<br><u>FEMALE</u>  | 4. RACE<br><u>WHITE</u>  | 5. DATE OF BIRTH MONTH <u>APR.</u> DAY <u>11</u> YEAR <u>1928</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>58</u> YRS.   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MARYLAND</u>  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE County</u> MD.                          |
| 12. CITY OR TOWN OF DEATH<br><u>TOWSON</u>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>STELLA MARIS HOSPICE</u> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>PROFESSOR</u> | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>EDUCATION</u>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>MARYLAND</u> |  | 13b. COUNTY <u>BALTO.</u>   | 13c. CITY OR TOWN <u>BALTO.</u>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST <u>HARRY</u> MIDDLE <u>TCHACK</u> LAST <u>TCHACK</u>   |  | 15. MOTHER'S MAIDEN NAME FIRST <u>FANNIE</u> MIDDLE <u>NUSINOV</u> LAST <u>NUSINOV</u>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>  |  | 16b. SOCIAL SECURITY NO. <u>220-20-0099</u>   |  | 17. INFORMANT ADDRESS <u>MISS DORI NEWMAN APT. 1304 111 HAMLET HILL RD. BALTO., MD 21210</u> |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) HEPATORENAL SYNDROME

DUE TO, OR AS A CONSEQUENCE OF

(c) METASTATIC BREAST CANCER

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0

MEDICAL CERTIFICATION

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <u>87</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2.29.87</u> to <u>2.10.87</u> that (I) (we) last saw the deceased alive on <u>2.10.87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |
| 22b. SIGNATURE <u>Carla S. Alexander MD</u>  |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <u>2.10.87</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Carla S. Alexander, M.D.</u>  |  | 22e. ADDRESS <u>Stella Maris Hospice Dulaney Valley Rd. - Towson, MD 21204</u>  |  |   |   |

|   |                                |  |   |
|---|--------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>         | 23b. DATE <u>FEB. 12, 1987</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MOSES MONTEFIORE WOODMOOR HEBREW</u> | 23d. LOCATION CITY OR TOWN <u>BALTO.</u> COUNTY <u>MD</u> STATE |
| 24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON &amp; BROS., INC.</u> |                                | 25a. DATE REC'D BY REGISTRAR <u>FEB 17 1987</u>                            | 25b. REGISTRAR'S SIGNATURE <u>Julia Dearden-Randall</u>         |
| 6010 REISTERSTOWN RD. BALTO., MD 21215                          |                                |  |   |



044273 FEB 12 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. The funeral director must retain this certificate and page 3 for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

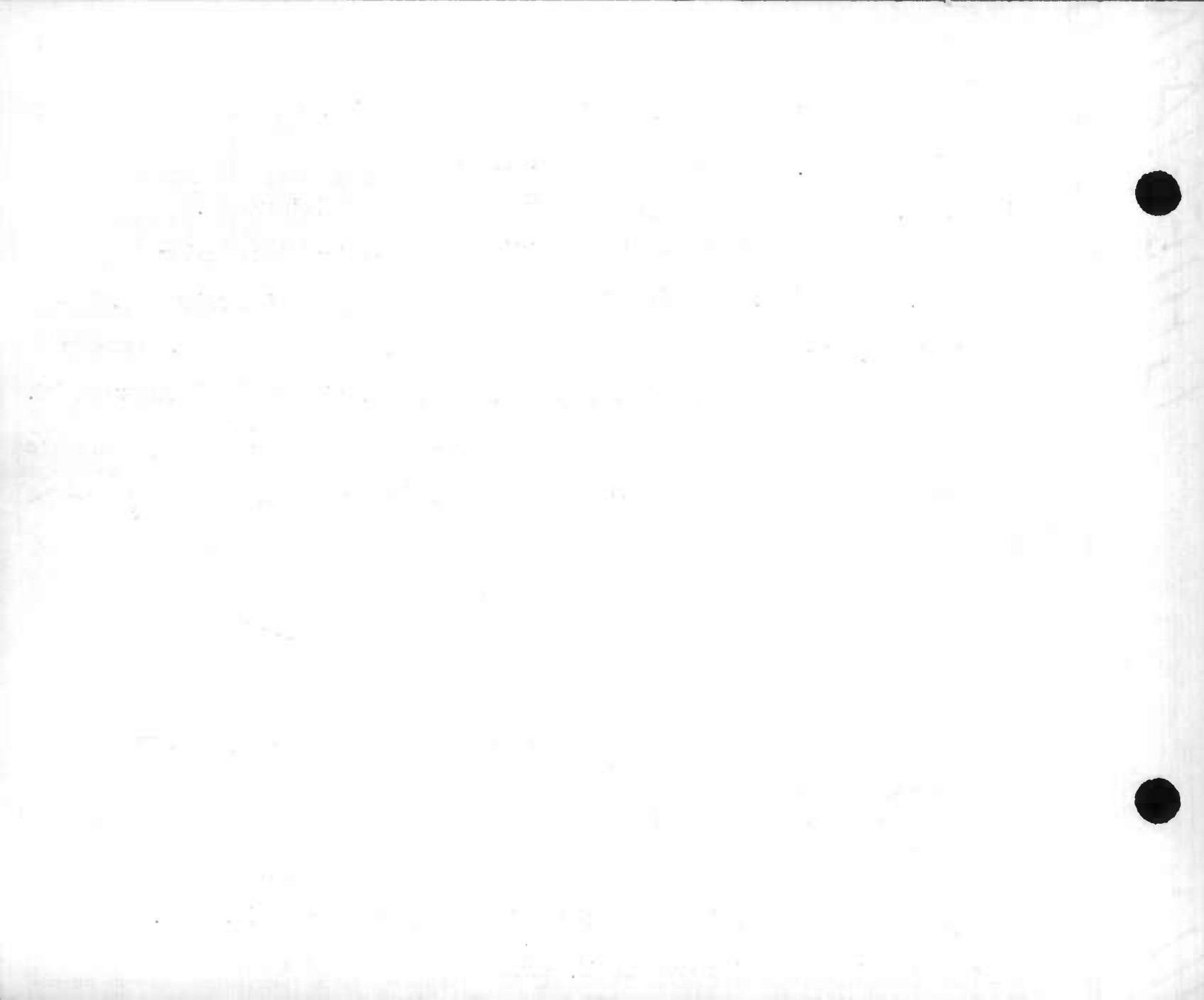
8703834

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |   |  |   |  |  |  |
|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William L. Niemeyer  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 15, 1987                   |  |  | 2b. HOUR<br>9:05 AM   |  |   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 5, 1904   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.                               |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(DO NOT INCLUDE CITY AND STREET ADDRESS)<br>Merridian Nursing Center |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Auto Dealer |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>Md.   |  |   | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Reisterstown                                      |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>11600 Reisterstown Rd. 21136 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William H. Niemeyer   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Caroline C. Baumann   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-32-3139 |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Frances F. Niemeyer Reisterstown, Md. |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>   |  |   |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>18 months   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Atherosclerosis</u>  |  |   |  |  |  |   |  |   | year   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF,<br>(c) _____  |  |   |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)          |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 5, 1904</u> to <u>Feb. 15, 1987</u> , that (I) (we) last saw the deceased alive on <u>Jan. 19, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>David D. McK...</u>  |  |   |  |  |  | DEGREE  |  |   | 22c. DATE SIGNED<br>2-16-87                                    |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>David D. McK...</u>   |  |   |  |  |  | 22e. ADDRESS<br><u>10212 S. Dafford Rd. Owingsville, Md.</u>                            |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>2/18/87   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery             |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville, Md.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Eline Funeral Home Reisterstown, Md. 21136  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 17 1987  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 37 should be detached for use as the burial-transit permit. Then please remove the following papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mary Regina Noel  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 25, 1987  |  | 2b. HOUR<br>2:30 A.M.  |
| 3. SEX<br>F  | 4. RACE<br>W  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>September 23, 1896  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co., MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2 Dowling Circle |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |  |  |
| 13a. STATE<br>Md.  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Towson   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>2 Dowling Circle 21234                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Anthony Rice   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Schmidt                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>219-34-4503   | 17. INFORMANT ADDRESS<br>William C. McDonnell 7111 Oxford Rd.<br>Baltimore, Md. 21212           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic Obstructive Pulmonary Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 weeks  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Arteriosclerotic Cardiovascular Disease</u>  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>JULY 24, 1985</u> to <u>FEB 25, 1987</u> , that (1) (we) last saw the deceased alive on <u>FEB 13, 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Walter R. Welzant</u> MD  |   |   |   | 22c. DATE SIGNED<br>FEB 25, 1987   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Walter R. Welzant   |   |   |   | 22e. ADDRESS<br>6100 York Rd., Baltimore, MD 21212                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>2/27/87  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Govans Presbyterian                      |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland   |   | 23e. DATE RECD. BY REGISTRAR<br>MAR 02 1987   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>MITCHELL-WIEDEFELD HOME, INC. Baltimore, Md. 21212   |   |   |   |  |  |

RECEIVED  
MAY 10 1964  
U.S. AIR FORCE

RECEIVED  
MAY 10 1964  
U.S. AIR FORCE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  | 87 03836   |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| FOR STATE REGISTRAR   |  |  |  |   |  |   |  |   |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANNA MARY NOPPENBERGER</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-9-87</b>                                  |  | 2b. HOUR<br><b>5 AM</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 27, 1910</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY MD.</b>                      |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeper</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Wholesale Fruit &amp; Produce</b>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |  |   |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. STREET ADDRESS / ZIP CODE<br><b>6101 Loch Raven Blvd. 21239</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael Patrick Noppenberger</b>   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gertrude M. Scally</b>            |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-10-7200A</b>   |  | 17. INFORMANT<br><b>Gertrude N. Kelly</b>   |  | ADDRESS<br><b>Same</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)        |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-2</b> , 19 <b>87</b> , to <b>2-9</b> , 19 <b>87</b> , that (I) (we) lost<br>saw the deceased alive on <b>2-6</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>DR. EDDIE NAKHUDA</b>  |  |  |  |   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2-9-87</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. EDDIE NAKHUDA</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>STELLA MARIS</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/12/87</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>              |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 11 1987</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |

20% COLUMBIAN

Handwritten notes and scribbles on the left margin.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

043578 FEB 10 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 / 03837

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Thelma Mary Norman</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 6, 1987</b>                              |   | 2b. HOUR<br>M<br><b>M</b>  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 21 1913</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>73</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Union Grove, N.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex 21221</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1211 Old Eastern Ave.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cafeteria worker</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Essex</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1211 Old Eastern Ave. 21221</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Speaks</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gillie L. Templeton</b>                 |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>219 20 7706</b>  |   | 17. INFORMANT ADDRESS<br><b>Lela M. Lambham, Daughter 1869 "B" I St. Grand Forks N.D. 58205</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Melanotic Carcinoma of pancreas.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)              |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March</b> 19 <b>86</b> to <b>Feb</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2-27</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (do) (do not) view the body after death.         |   |   |   |   |  |
| 22b. SIGNATURE<br><b>R. Perez-Mera</b>   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>2-8-87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. Perez-Mera</b>  |   | 22e. ADDRESS<br><b>406 Eastern Blvd. 21221</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   | 23b. DATE<br><b>2/11/87</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Thurmond Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elkins, N.C.</b>                               |  |
| 24. FUNERAL DIRECTOR<br><b>Wazdzinski Funeral Home PA 1407 Old Eastern Ave</b>   |   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Swinson-Rudner</b>                                       |  |

BP

February 6, 1907

Union County

1211 Old Western Ave.

1211 Old Western Ave.

1211 Old Western Ave.

1211 Old Western Ave.

1211 Old Western Ave.



February 6, 1907

February 6, 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |   |   |   |  |
|--|--|---|--|--|--|---|---|---|---|--|
| 1- FOR STATE REGISTRAR   |  |   |  |  |  |   |   |   |   |  |
| 7a DECEASED NAME (TYPE OR PRINT)   |  |   | FIRST MIDDLE LAST  |  |  | 7b DATE OF DEATH  |   | MONTH DAY YEAR  |   |  |
| Anne C. Norton   |  |   |  |  |  | 2 20 1987   |   | 10:15 PM  |   |  |
| 3 SEX  |  | 4 RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                 |   | IF UNDER 1 YEAR   |   |  |
| Female   |  | White   |  | MONTH DAY YEAR<br>12 24 1913   |  | 73 YRS.   |   | IF UNDER 24 HRS.  |   |  |
| 7a BIRTHPLACE (COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                            |   |   |   |  |
| Massachusetts  |  | U. S. A.  |  |  |  | Baltimore County, MD.   |   |   |   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b KIND OF BUSINESS OR INDUSTRY                              |   |  |
| Phoenix  |  | 14000 Manor Road  |  |  |  | Homemaker   |   | Domestic  |   |  |
| 13a STATE  |  |   |  |  | 13b COUNTY   |   | 13c CITY OR TOWN  |   | 13d INSIDE CITY LIMITS?   |  |
| Maryland   |  |   |  |  | Baltimore  |   | Phoenix   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME   |  |   |  |  | 15 MOTHER'S MAIDEN NAME  |   |   |   |   |  |
| FIRST MIDDLE LAST<br>Dennis Corcoran   |  |   |  |  | FIRST MIDDLE LAST<br>Margaret Guthrie  |   |   |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)               |  | 17 INFORMANT ADDRESS   |   |   |   |   |  |
| No   |  |   | 024-28-2161  |  | Anne Grason 14000 Manor Road Phoenix, Md.                                    |   |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cause of Pancreatic metastasis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cause of Pancreas</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASCVD</u>   |  |   |  |  |  |   |   |   |   |  |
| 19a DATE OF OPERATION  |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  |  | 20a AUTOPSY?  |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |  |
|  |  |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>        |   | YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |   |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>12/30</u> 19 <u>86</u> , to <u>2/20</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |   |   |   |  |
| 22b SIGNATURE<br><u>Shanya</u>   |  |   |  |  | DEGREE   |   | 22c DATE SIGNED   |   |   |  |
| 22b PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |  | 22c ADDRESS  |   |   |   |   |  |
| F SAUZZARO   |  |   |  |  | 3313 PARKER MIL Rd   |   |   |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE   |   |   |  |
| Burial   |  |   | 2-24-87  |  | Mt. Auburn Cemetery  |   | Cambridge, Middlesex, Mass.   |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Marzullo Funeral Service  |  |   |  |  | ADDRESS<br>Upperco, Md.  |   | 25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE<br>FEB 25 1987 Julia Davidson-Rodriguez |   |   |  |

BP

121

1987 FEB 23

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been reviewed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial permit. This page must be filed with the funeral director's office within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows only a copy of a traumatic event, the medical examiner must be notified of this.

DHMH - 16 60M 7/84  
(VRS 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 87 03839   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>John T. Norton, JR.  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>02 19 87  |  |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>AUG. 19, 1913  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br>73 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Baltimore Medical Center |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MECHANIC   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AUTOMOTIVE   |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>PHOENIX  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOHN T. NORTON, SR.   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>BLANCHE FRENCH  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE UNKNOWN) YES   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>W.W. 11  |  | 17. INFORMANT ADDRESS<br>EVELYN C. NORTON PHOENIX, MD 21131   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Massive M.I.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Respiratory Arrest</u>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>February 12, 1987</u> to <u>February 19, 1987</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>February 19, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |  |  |   |  |   |  |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED <u>2/19/87</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Vik Poonai, M.D.  |  |  |  | 22e. ADDRESS<br>G.B.M.C.  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>FEB. 21, '87  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHESTNUT GROVE CHURCH   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE CO., MD  |  |
| 24. FUNERAL DIRECTOR NAME<br>WILLIAM E. JOHNSON  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>FEB 20 1987 <u>[Signature]</u>  |  |   |  |

MEDICAL CERTIFICATION





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 3 8 4 0

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |   |  |                                     |  |
|--|--|--|---|--|-------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Gerard Joseph Novak</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>February 24, 1987</i> |  | 2b. HOUR<br>MIN.<br><i>12:20 A.</i> |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YRS<br><i>1 22 31</i>  |                                     |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>56</i>   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>              |   | 8. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |                                     |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 10. CITY OR TOWN OF DEATH<br><i>Eastwood</i>                             |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>7253 Conley Street</i> |                                     |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><i>Expediter</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Beth. Steel</i>                  |   | 13. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.   |                                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Eastwood</i>   |                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Benjamin Novak</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Agnes Konchinski</i> |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>Yes Korean</i>                   |                                     |  |
| 17. SOCIAL SECURITY NO.<br><i>215-28-2079</i>  |  | 18. INFORMANT<br><i>Gloria C. Novak</i>                                  |   | 19. ADDRESS<br><i>7253 Conley Street 21224</i>   |                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>lung cancer</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 wks</i> |  |  |   |  |                                     |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |   |  |                                     |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                     |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |                                     |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/1</i> , 19 <i>86</i> , to <i>2/24</i> , 19 <i>87</i> that (I) (we) last saw the deceased alive on <i>2/24/87</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |                                     |  |
| 22b. SIGNATURE<br><i>Schnuchter</i>  |  | DEGREE<br><i>MD</i>  |   | 22c. DATE SIGNED<br><i>2/26/87</i>   |                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Schnuchter</i>   |  | 22e. ADDRESS<br><i>Johns Hopkins Hospital</i>                            |   |  |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>2-27-87</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Oak Lawn Cemetery</i>   |                                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Eastwood, Baltimore Co., Md.</i>  |  | 24. FUNERAL DIRECTOR<br><i>Charles S. Zeiler &amp; Son Inc.</i>          |   | 25. DATE REC'D. BY REGISTRAR<br><i>FEB 27 1987</i>   |                                     |  |
| 25a. ADDRESS<br><i>6224 Eastern Ave.</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>              |   |  |                                     |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. This permit must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 3 8 4 1

REG. NO.

1. FOR  
STATE  
REGISTRAR

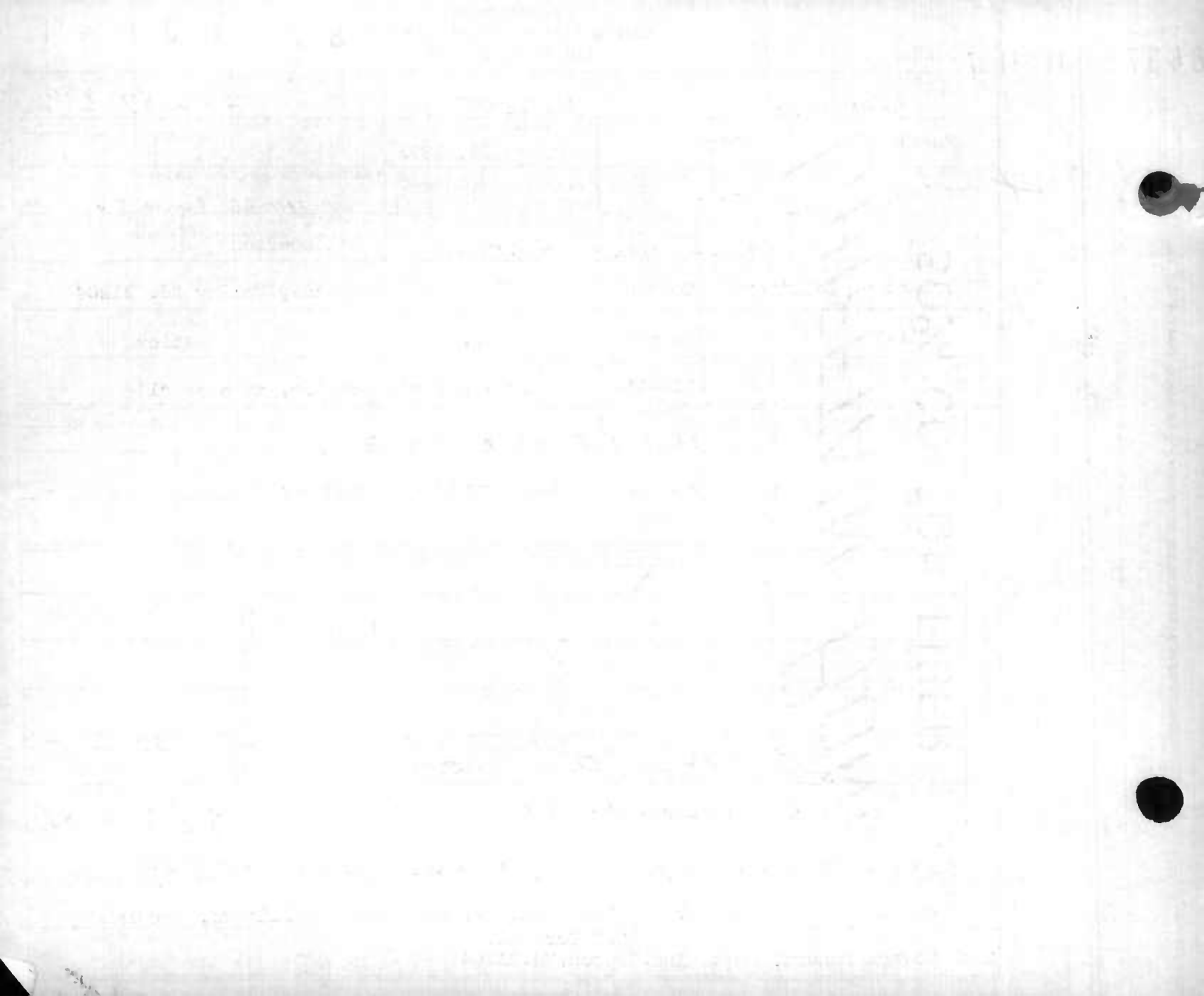
|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GERTRUDE NUGENT</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-6-87</b>                                   |   | 2b. HOUR<br><b>6<sup>30</sup> PM</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 21, 1895</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS.                         | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD</b>        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>STELLA MARIS HOSPICE</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesperson</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Towson</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel Nugent</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura Stier</b>                    |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-01-2172</b>  |  | 17. INFORMANT ADDRESS<br><b>Stella Maris Hospice, same as #13e</b>        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PROBABLE ARRHYTHMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause, (a), stating the underlying cause lost. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)        |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-1</b> , 19 <b>86</b> , to <b>2-6</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>1-26</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Carla A. Alexander MD</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>2-6-87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARLA ALEXANDER</b>  |  | 22e. ADDRESS<br><b>STELLA MARIS HOSPICE</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2-10-87</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1987</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                          |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate and other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

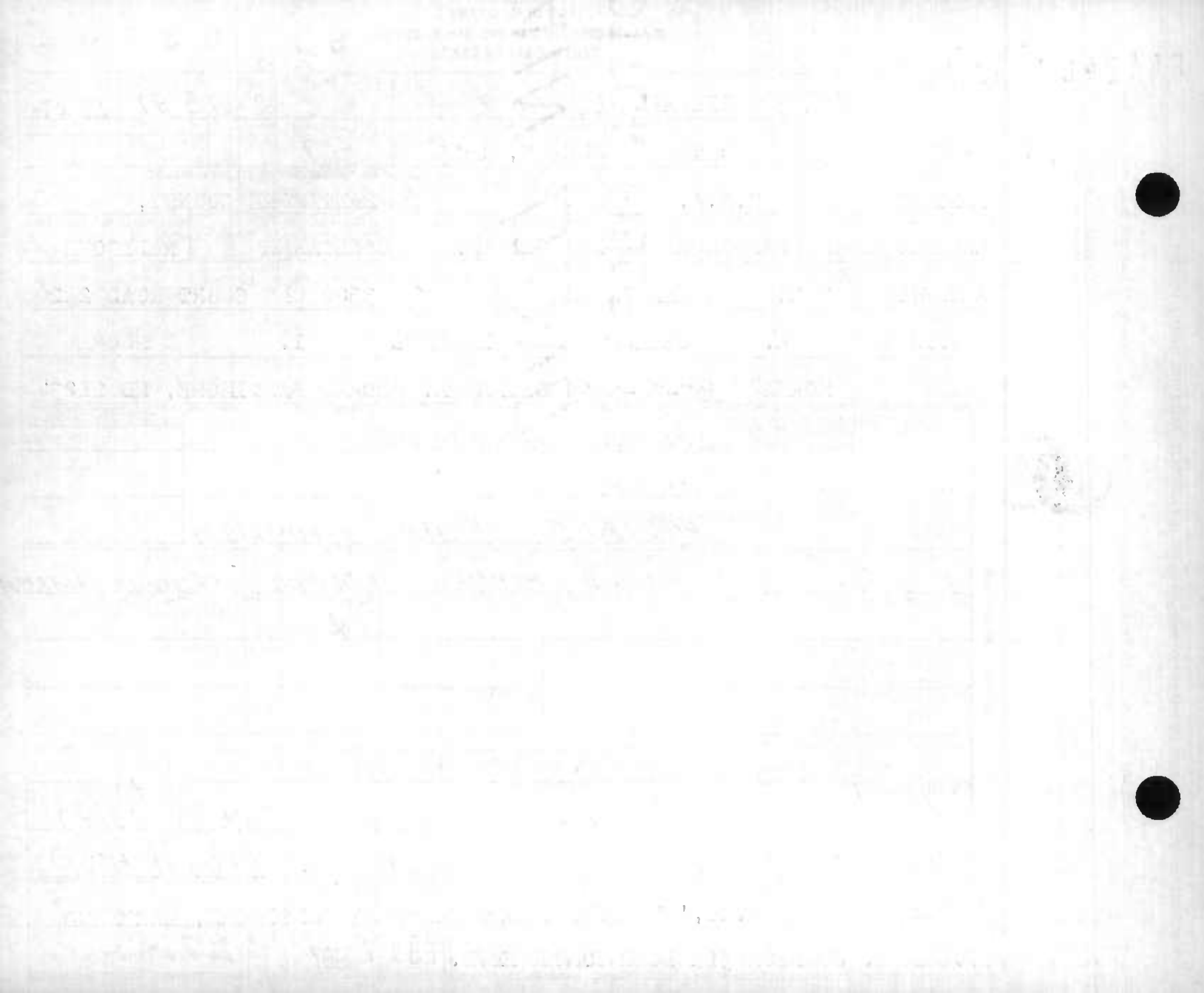
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03842

REG. NO.

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| 11. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |   | MIN.   |  |
| JAMES RICHARD OBCAMP   |  | 2 13 87  |   | 0223M  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               | 7. IF UNDER 1 YEAR   |  |
| MALE   | WHITE  | JUNE 7, 1929   | 57  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |
| ILLINOIS   | U.S.A.   |  | BALTIMORE COUNTY, MD.   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| RANDALLSTOWN   | BALTIMORE COUNTY GENERAL   |  | CARETAKER   |  | RELIGIOUS                                    |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. CITY OR TOWN  |   | 13c. STREET ADDRESS / ZIP CODE   |  |
| 13a. STATE   |  | 13b. CITY OR TOWN  |   | 13c. STREET ADDRESS / ZIP CODE   |  |
| MARYLAND   |  | BALTIMORE  |   | 3300 OLD COURT ROAD 21208  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   |  |  |
| WILLIAM R. OBCAMP  |  | FLORENCE I. MOORE  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |  |
| YES  |  | KOREA 557-34-3835  |   | GAYLEE L. OBCAMP BALTIMORE, MD 21234   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>SHOCK</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>POSSIBLE PULM EMBOLISM</u>  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>C.V.A., G.I. BLEED, HEPARIN INDUCED THROMBOCYTOPENIA</u>   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |  |
|  |  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |   |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION  |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   | CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |  |
| Hafeez A Syed  |  |  |   | 2/13/87  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |  |
| HAFAEEZ A SYED   |  | BALTIMORE COUNTY GEN HOSP.   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| CREMATION  |  | FEB. 16, '87   |   | GREEN MOUNT CEMETERY BALTIMORE, MARYLAND                                       |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |
| WILLIAM E. JOHNSON   |  | FEB 17 1987  |   | John Deaton-Rudace   |  |

BP.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon copiers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal investigation should be notified at the time of death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 3 8 4 3  
REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT)<br><b>BARBARA E. OBENDORFER</b><br><i>Barbara Obendorfer</i>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEB 9 87</b>   |  | 2b. HOUR<br><b>7:51 AM</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>white</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>6-23-07</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS.<br><b>79</b> YRS MONTHS DAYS HOURS MIN.                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian-Perring Pkwy. Nursing Home</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Telephone Operator-Tel. Co.-Md.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. STREET ADDRESS / ZIP CODE<br><b>603 E. 30th. St. 21218.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Michael -- Obendorfer</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Margaret -- Hoehl</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-0026</b>   |  | 17. COUSIN: Mildred A. Farrell<br><b>212-05-0026-1514 Kennewick Road; Balto., Md. 21218</b>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Encephalopathy-CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>C.V.A.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b> |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>11-9-83</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br><b>21218</b>   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-9-87</b> to <b>2/9/87</b> , that (I) (we) lost saw the deceased alive on <b>2-9-87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) did not view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Anthony Carozza MD</b>  |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>2-9-87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Anthony F. Carozza</b>   |  |  |  | 22e. ADDRESS<br><b>4214 MANORWOOD DR BALTO MD 21057</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/11/87</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery-Baltimore, Maryland</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Sterling Funeral Estate, P.A.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 10 1987</b>   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>736 Edmondson Ave.; Catonsville, Md. 21228.</b>   |  |  |  |   |  |   |  |

MEDICAL CERTIFICATION





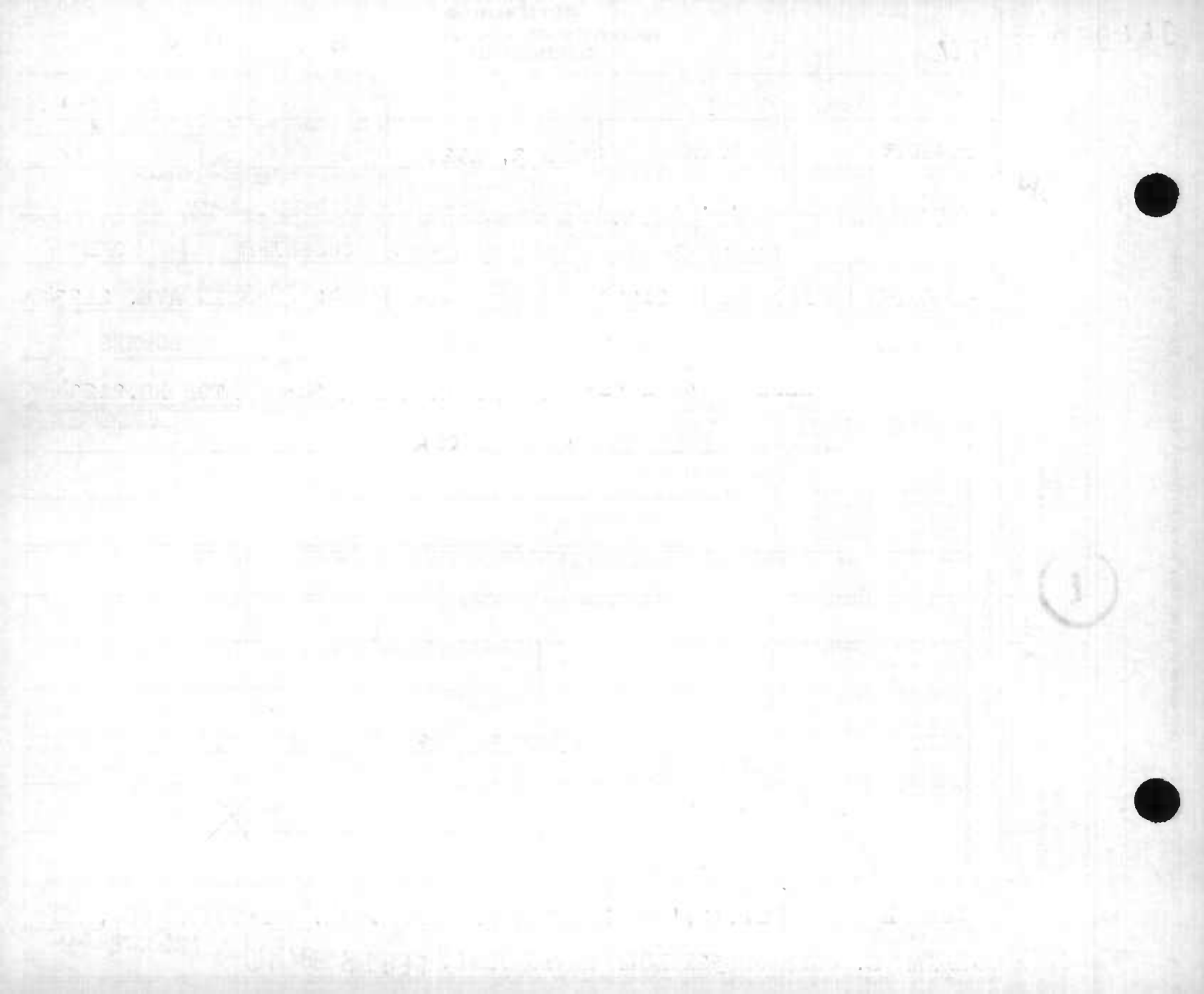
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. When page 3 is detached, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above, immediately, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 7 0 3 8 4 4<br>REG. NO.   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Vera L. Onheiser  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>02 11 87<br>2b. HOUR<br>3:15 p.m.   |  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>JUNE 3, 1920   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Baltimore Medical Center |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME  |  |
| 13a. STATE<br>MARYLAND   |  |   |  | 13b. CITY OR TOWN<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>21234   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>RUSSELL MYERS   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ROSE BOWERS   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----  |  | 17. INFORMANT ADDRESS<br>CAROL A. SMITH 1308 DALTON RD. 21234   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Breast Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>February 4, 1987</u> to <u>February 11, 1987</u> , that (I) (we) last saw the deceased alive on <u>February 11, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Kelly MD</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Kelly, Tom</u>   |  |   |  | 22c. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>FEB. 13, '87   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>DULANEY VALLEY MEM.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>GAR. BALTIMORE CO., MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WILLIAM E. JOHNSON   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 13 1987  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia London-Ruback</u>   |  |
| ADDRESS<br>8521 LOCH RAVEN BLVD.   |  |   |  |   |  |  |  |

BP



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03845

|   |  |   |   |   |   |  |  |  |  |
|---|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/14/87</b> |   |   | 2b. HOUR<br><b>3:45</b> AM   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 10 1908</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE Co.</b> MD.                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 NORTH CHARLES ST.</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Florida Broward Tamarac</b>  |  |   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6305 Brookwood Blvd., Florida 33319</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John K. Tatosian</b>   |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Arax Chakerian</b>                          |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>264-47-0523</b>  |   | 17. INFORMANT ADDRESS<br><b>Haig R. Oundjian 8006 Rider Ave., 21204</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Alzheimer's disease</b>  |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 13, 1987</b> to <b>FEBRUARY 14, 1987</b> , that (I) (we) lost saw the deceased alive on <b>FEBRUARY 14, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><i>Arthur A. Smith</i>  |  |   |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>2/14/87</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARTHUR A SMITH</b>  |  |   |   |   | 22e. ADDRESS<br><b>6701 North Charles Street, Towson, MD 21204</b>                              |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>2/16/87</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Balto. Md.</b>          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Martin D. Lawson</b>   |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1987</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>                             |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to Postmaster. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

370-1728

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>James Melvin Parker  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02-21-1987             |   |  | 2b. HOUR<br>16 20 M   |  |
| 3. SEX<br>male   |  | 4. RACE<br>white   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05-05-1905  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret-US Soldiers & Airmans Home  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Owings Mills |  |  |   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE<br>72 Meriam Ct. 21117 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George C. Parker   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice Sheran |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>--- 213-05-9171   |   | 17. INFORMANT<br>Owings Mills ADDRESS MD 21117<br>Mrs. Olwen M. Parker 72 Meriam Ct.  |  |   |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cardiogenic shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Acute Infarction with Myocardial Infarction</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-21</u> , 19 <u>87</u> , to <u>2-21</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>2-21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Allen J. Churchill M.D.</u><br>22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Allen J. Churchill M.D.</u>   |  |  |  | 22c. DATE SIGNED<br><u>2-21-87</u>   |  |
| 22e. ADDRESS<br><u>Balt. County General Hosp</u>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>2-24-87</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore Cemetery</u>                      |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore City MD</u>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Loring Byers Funeral Directors, Inc</u><br><u>8728 Liberty Rd. Randallstown, MD 21133</u>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 23 1987</u>                                  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julian Dandrea-Randrea</u>                          |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate and carbon copies, pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, entombment, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please return carbon copies. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 87 03847   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Richard F. Parker Sr</u>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>2-24-1987</u>  |  |   |  |
| 3. SEX<br><u>male</u>   |  | 4. RACE<br><u>white</u>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>07-05-1931</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>55</u> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Maryland</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>United States</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore County</u> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Randallstown</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Baltimore County General Hospital</u> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Retired- Rosewood Center</u>                        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>Maryland</u> 13b. COUNTY <u>Baltimore</u> 13c. CITY OR TOWN <u>Owings Mills</u>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><u>25 Strawhat Road Apt. 1B 21117</u>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>Melvin James Parker</u>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Catherine Brown</u>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><u>no</u>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><u>214-26-4104</u>   |  | 17. INFORMANT Mrs. Mary Parker ADDRESS<br><u>25 Strawhat Road Apt. 1B Owings Mills, MD. 21117</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-Pulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Multiple microbial sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>EMPHYSEMA</u>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-11-87</u> to <u>2-24</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2-24</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Allen J. Chircus M.D.</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><u>2-24-87</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Allen J. Chircus M.D.</u>   |  |  |  | 22e. ADDRESS<br><u>Balt. County General Hosp</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>2/27/87</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Druid Ridge Cemetery</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Pikesville Baltimore MD.</u>  |  |
| 24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. NAME ADDRESS<br><u>8728 Liberty Road Randallstown, MD. 21133</u>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><u>MAR 02 1987 Julia Davidson-Rodriguez</u>   |  |   |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, to move casket to place of burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRS 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 3 8 4 8  
REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Theresa Sarah Parker   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 12, 1987  |  | 2b. HOUR<br>0645 M   |
| 3. SEX<br>Female  | 4. RACE<br>Caucasian   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 20 1899  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                          |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>--                      |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Woodlawn   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>13 White Cliff Court 21207 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Hugh McGowan  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Worrell                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-54-2707  |   | 17. INFORMANT<br>Baltimore ADDRESS MD 21207<br>Mr. Jesse Parker 13 Whitecliff Ct.    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cardiorespiratory Arrest  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Sudden    |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Atherosclerotic Heart Disease Congestive Heart Failure  |  |   |   |  | Years  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>Chronic Atrial Fibrillation, Old Anteroseptal Infarction, Aortic Stenosis, Right Bundle Branch Block  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1982 to February 1987, that (we) last saw the deceased alive on February 12, 1987, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br>Herman Brecker M.D.   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>2/12/87  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Herman Brecker   |  | 22e. ADDRESS<br>6410 Windsor Mill Road 21207  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>2-16-87  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem.                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City MD   |  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Rd. Randallstown, MD 21133   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 17 1987  |   | 25b. REGISTRAR'S SIGNATURE<br>Julius [Signature]                                     |  |

BP

6-10-1918

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above.

I am sorry to hear that you are having trouble with your engine. I will try to get you a new one as soon as possible.

I am, Sir, very respectfully,  
Yours,  
J. H. [Name]

10-10-1918

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

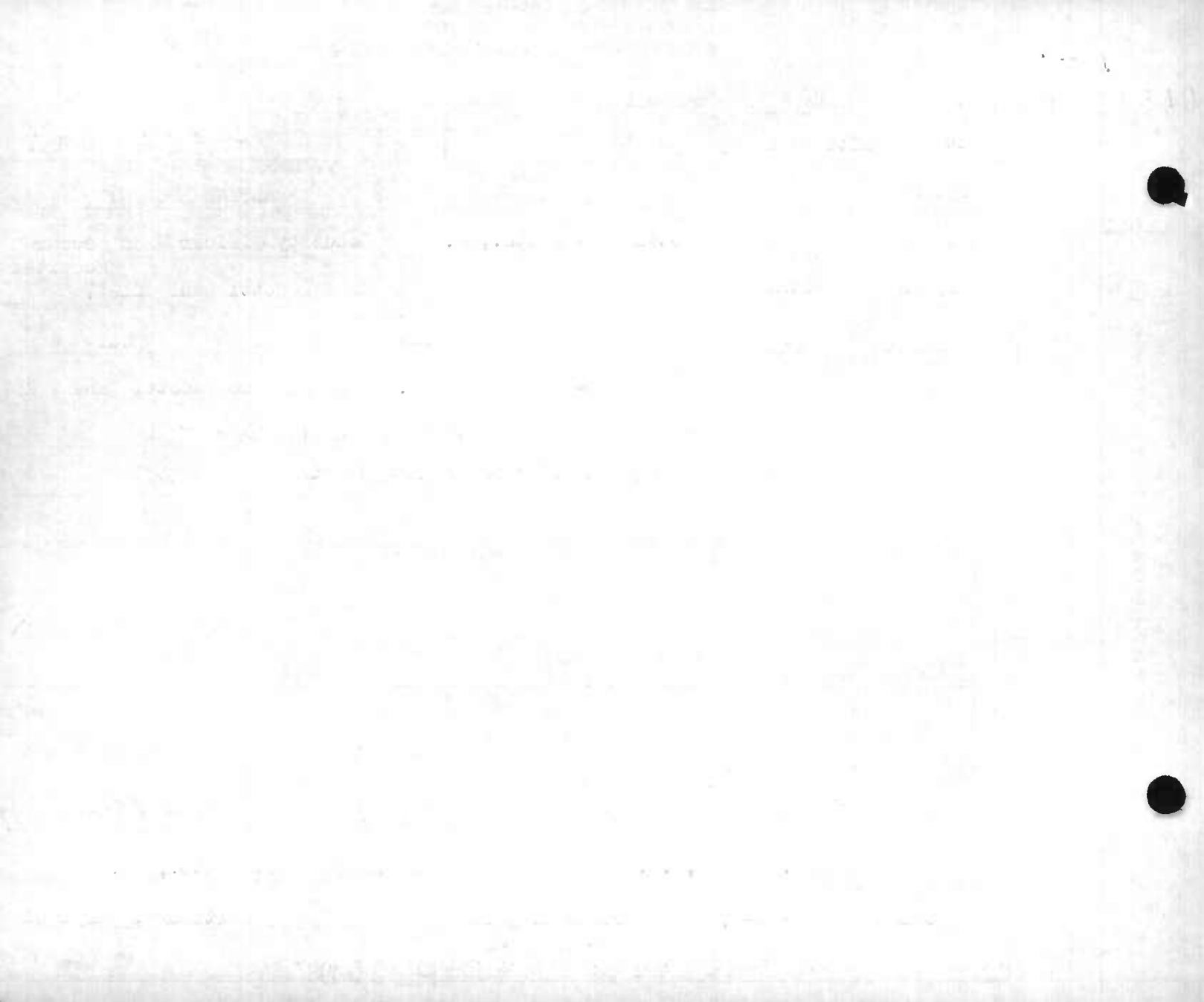
REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                  |   |  |   |   |  |   |  |
|--|------------------|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Louis Carroll Passapae  |                  |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>19                        |   |   | 2b. HOUR<br>M  |   |  |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 25 33   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>53 YRS.                        | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>FEB 23 19 87                           |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.       |   |  |
| 10. CITY OR TOWN OF DEATH<br>Rosedale  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8208 LaCotti Lane Balto., Md. |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Security Officer |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bon Secour                                     |  |
| 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Hospital   |                  |   |  |   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Carroll Joseph Passapae  |                  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Soul            |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-30-5229 |   |   | 17. INFORMANT ADDRESS<br>Wilma C. Passapae 8208 LaCotti Lane 21237 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIO -</u><br>DUE TO, OR AS A CONSEQUENCE OF<br><u>VASCULAR DISEASE</u><br>Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)            |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |   |  |   |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Paul F. Guerin</i>  |                  |   | TITLE (SPECIFY)<br>M.D. DEPUTY   |   |   | MEDICAL EXAMINER   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Paul F. Guerin, M.D.  |                  |   | ADDRESS<br>1201 Krueger Ave. Balto., Md.                               |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                  | 23b. DATE<br>2-26-87  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lassaph Funeral Home   |                  |   | ADDRESS<br>7401 Belair Rd. BALTO. MD. 21236                            |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 25 1987                                      |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Twicken-Pandora</i>                          |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM RM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT (PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE - DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



043643 FEB

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please affix the seal of the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |  |   |  |                                   | 87 03850  |  |
|---|--|---|--|---|---|--|---|--|-----------------------------------|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |   |  |   |  |                                   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Evelyn S. Patton</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 4, 1987</b>                                  |  |   | 2b. HOUR<br><b>10:50 a</b>   |                                   | m   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>(MONTH DAY YEAR)<br><b>July 12 1922</b>   |   | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>64</b>                                |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>YRS</b>                            |                                   | 8. IF UNDER 24 HRS  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.            |   |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(AND IN SUCH CITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired - RR</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>Md.</b> 13b COUNTY <b>Balto.</b> 13c CITY OR TOWN <b>Essex</b>   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>12 Terrace Road 21221</b>                          |  |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Emory Sewell</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                 |  |   |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  |  |   |  |   | 16b. SOCIAL SECURITY NO<br><b>216-16-3556</b>   |  | 17. INFORMANT ADDRESS<br><b>William Patton 12 Terrace Rd. 21221</b>                     |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Gastrointestinal bleeding</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |   |   |  |   |  |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>  |  |   |  |   |   |  |   |  |                                   |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>February 4, 1987</b> to <b>February 4, 1987</b> , that (I) (we) last saw the deceased alive on <b>February 4, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |   |  |                                   |   |  |
| 22a. SIGNATURE<br><b>Alfred J. Covington MD</b>   |  |   |  |   |   | DEGREE   |   |  | 22c. DATE SIGNED                  |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alfred J. Covington, M.D.</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>                       |   |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |   |  | 23b. DATE<br><b>2/7/87</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Cemetery</b>               |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Middle River Balto. Md.</b>         |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Connelly Funeral Home 300 Mace Ave. 21221</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FFB 10 1987</b>                            |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>                                  |                                   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 87 03851<br>REG. NO.  |  |  |  |                            |
|--|--|---|--|---|--|--|--|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET Evans PEARCE</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2/27/87</b>  |  |  |  | 2b. HOUR<br><b>8:45 P.</b> |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 27, 1890</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>97</b> YRS.  |  |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.   |  |                            |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County Gen. Hosp.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |                            |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br><b>21111</b><br><b>16425 J. M. Pearce Road</b>   |  |                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Evans</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Cowan</b>  |  |  |  |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-10-5314</b>  |  | 17. INFORMANT ADDRESS<br><b>Margaret Smith same as above</b>  |  |  |  |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sensitivity</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |   |  |   |  |  |  |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____   |  |   |  |   |  |  |  |                            |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |                            |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |                            |
| 22b. SIGNATURE<br><b>W. N. Iglewicz</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>2/27/87</b>   |  |                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. N. IGLEWICZ</b>   |  |   |  | 22e. ADDRESS _____  |  |  |  |                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/2/1987</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. James Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Monkton, Baltimore Md.</b>  |  |                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>M. Gladden Kurtz Jarrettsville, Md.</b>   |  |   |  | 25. DATE RECD. BY REGISTRAR (DATE, SIGNATURE)<br><b>MAR 04 1987</b>   |  |  |  |                            |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of this certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (If the deceased was a resident of Maryland, it should be filed with 72 hours after death.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and autopsy performed.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 03852

|   |  |   |   |  |                                   |  |          |         |
|---|--|---|---|--|-----------------------------------|--|----------|---------|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |   | MONTH  | DAY                               | YEAR   | 2b. HOUR |         |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST   | MIDDLE  | LAST   |                                   |  |          |         |
| Martin  |  | D.  | Pennewill   |  | 02 04 87                          |  |          | 12:18pm |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                   | 7. IF UNDER 1 YEAR   |          |         |
| Male  | White  | MONTH DAY YEAR<br>March 20, 1901  |   | 85 YRS.  |                                   | IF UNDER 24 HRS.   |          |         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   |  |          |         |
| MD  | USA  |   |   | Baltimore County MD  |                                   |  |          |         |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |          |         |
| Towson  | Greater Baltimore Medical Center   |   | Nickel Plater   |  | Manufacturing                     |  |          |         |
| 13a. STATE  |  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS / ZIP CODE    |  |          |         |
| MD  |  | Balto.  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 2100 E. Joppa Rd., 21234          |  |          |         |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |   |  |                                   |  |          |         |
| FIRST MIDDLE LAST<br>Elmer Leslie Pennewill   |  | FIRST MIDDLE LAST<br>Katie B. Lynch   |   |  |                                   |  |          |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT  |                                   | ADDRESS  |          |         |
| No  |  | 215 07 4349   |   | Mrs. Clara E. Pennewill,   |                                   | Same   |          |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute subendocardial M.I.</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio sclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic obstructive lung disease; congestive heart failure</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Rabhdomyolysis (?)</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> |  |   |   |  |                                   |  |          |         |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |         |
|   |  |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) |                                   |  |          |         |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |  |          |         |
| 22a. I certify that (A) (this hospital) attended the deceased from <u>February 2, 1987</u> , to <u>February 4, 1987</u> , that (I) (we) last saw the deceased alive on <u>February 4, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) did not view the body after death.   |  | 22b. SIGNATURE<br><u>Ruben S. Sebastian</u>   |   | DEGREE<br><u>M.D.</u>  |                                   | 22c. DATE SIGNED<br><u>2/5/87</u>                              |          |         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |   |  |                                   |  |          |         |
| Ruben S. Sebastian, M.D.  |  | G.B.M.C.  |   |  |                                   |  |          |         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |          |         |
| Burial  |  | 2/9/87  |   | Fallston United Meth.  |                                   | Fallston, MD   |          |         |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |                                   |  |          |         |
| Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |  | FEB 6 1987  |   | <u>Julia Dindon-Rudner</u>   |                                   |  |          |         |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |                                      |  |  |  | 87 03853   |     |   |  |  |  |
|---|--|--|--|---|--|--------------------------------------|--|--|--|--|-----|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  | REG. NO.   |  |   |  |                                      |  |  |  |  |     |   |  |  |  |
| 1. DECEASED NAME (LAST OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST                                 |  | 2a. DATE OF DEATH  |  | MONTH  | DAY | YEAR  | 2b. HOUR                                     |  |  |
| Helen   |  | PERRY  |  |   |  |                                      |  | February 7, 1987   |  |  |     |   | 4:45p <sub>M</sub>                           |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |     |   |  |  |  |
| Female  |  | White  |  | Jan. 7 1915   |  | 72 YRS.                              |  | MONTHS   |  | DAYS   |     | HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |     |   |  |  |  |
| Maryland  |  | USA  |  |   |  | Baltimore County MD.                 |  |  |  |  |     |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |                                      |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |     | 12b. KIND OF BUSINESS OR INDUSTRY                                     |  |  |  |
| Rossville   |  | Franklin Square Hospital   |  |   |  |                                      |  |  |  | Retired  |     |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13b. CITY OR TOWN   |  |                                      |  | 13c. INSIDE CITY LIMITS?   |  |  |     | 13d. STREET ADDRESS / ZIP CODE  |  |  |  |
| Md. STATE   |  |  |  | Balto. COUNTY   |  |                                      |  | Essex  |  |  |     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> * |  |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |                                      |  |  |  |  |     |   |  |  |  |
| Coleman   |  |  |  | Smith Sr.   |  |                                      |  | Anna   |  |  |     | Caroline Franhold   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  |                                      |  | 17. INFORMANT  |  |  |     | ADDRESS   |  |  |  |
| no  |  |  |  | 215-07-3547   |  |                                      |  | Joan Morgan  |  |  |     | 440 Margaret Ave. 21221   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |                                      |  |  |  |  |     |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |                                      |  |  |  |  |     |   |  |  |  |
| IMMEDIATE CAUSE (a)   |  |  |  |   |  |                                      |  |  |  |  |     |   | ACUTE RESPIRATORY FAILURE                    |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |  |                                      |  |  |  |  |     |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |                                      |  |  |  |  |     |   | PNEUMONIA                                    |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |                                      |  |  |  |  |     |   | SEVERE MITRAL STENOSIS                       |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |   |  |                                      |  |  |  |  |     |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                      |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |     |   |  |  |  |
|   |  |  |  |   |  |                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |     |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY   |  |                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |     |   |  |  |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR  |  |                                      |  |  |  |  |     |   |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY  |  |                                      |  | 21f. LOCATION  |  |  |     |   |  |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |                                      |  | STREET CITY OR TOWN COUNTY STATE   |  |  |     |   |  |  |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>January 23</u> , 19 <u>87</u> , to <u>February 7</u> , 19 <u>87</u> , that (I) <u>we</u> last saw the deceased alive on <u>February 7</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death. |  |  |  |   |  |                                      |  |  |  |  |     |   |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  |                                      |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |     | 22c. DATE SIGNED  |  |  |  |
| <i>K. Steptoe M.D.</i>  |  |  |  |   |  |                                      |  |  |  |  |     | 2-7-87  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |                                      |  |  |  |  |     |   |  |  |  |
| K. Steptoe M.D.   |  |  |  | 9000 Franklin Square Drive  |  |                                      |  |  |  |  |     |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |  |     |   |  |  |  |
| Burial  |  |  |  | 2/11/87   |  | Holly Hill Cemetery                  |  | CITY OR TOWN COUNTY STATE  |  |  |     |   |  |  |  |
|   |  |  |  |   |  |                                      |  | Middle River Balto. Md.  |  |  |     |   |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |                                      |  | 25b. REGISTRAR'S SIGNATURE   |  |  |     |   |  |  |  |
| NAME  |  |  |  | ADDRESS   |  |                                      |  |  |  |  |     |   |  |  |  |
| Connelly Funeral Home   |  |  |  | 300 Mace Ave. 21221   |  |                                      |  | FEB 10 1987 <i>Lia Davidson-Randall</i>  |  |  |     |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove common papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after hospital event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 7 0 3 8 5 4   |  |  |  |
|--|--|--|--|---|--|--|--|
| FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Beulah E. Phillips</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-13-1987</b>   |  | 2b. HOUR<br><b>1:09 P.M.</b>   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-4-1903</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. Co.</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>G.B.M.C.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b>   |  |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br><b>3009 Christopher Ave. 21214</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Webster W. Phillips</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie T. Howard</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO<br><b>217-01-8186</b>  |  | 17. INFORMANT<br>ADDRESS <b>Lutherville, Md. 21093</b><br><b>Robert W. Phillips, 822 Kellogg Rd.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>GI bleeding</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus, in terminal natural degeneration, recent myocardial infarct</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><b>Diabetes Mellitus, in terminal natural degeneration, recent myocardial infarct</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>September 30 19 86</b> to <b>February 13 19 87</b> , that (I) (we) last saw the deceased alive on <b>February 8 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (and not) view the body (or bodies).  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Alicia A. Cool-Foley, M.D.</b>  |  |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/13/87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alicia A. Cool-Foley, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>Union Memorial Hosp.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-16-87</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1987</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Alicia Cool-Foley</b>   |  |

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FOR  
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME  
 (TYPE OR PRINT) William Norton Pitman, III  
 WILLIAM PITTMAN, III

2a. DATE KNOWN OF DEATH  
 ESTIMATED 2-9-87 19

3. SEX Male  
 4. RACE White  
 5. DATE OF BIRTH JULY 22, 1950 37 YRS.  
 6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.

7b. DATE PRONOUNCED DEAD 2-9-87 19 4:05 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND  
 7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐  
 WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD

10. CITY OR TOWN OF DEATH Towson

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN

12b. KIND OF BUSINESS OR INDUSTRY PLUMBING

13a. STATE MARYLAND  
 13b. CITY FULLERTON

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS 4126 GRAPE HILL AVENUE 21236

14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM NORTON PITMAN

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BETTY BERKLEY SANFORD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO

16b. SOCIAL SECURITY NO. 215 56 6700

17. INFORMANT ADDRESS WILLIAM N. PITMAN 4126 GRAPE HILL AVENUE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) Cardiomyopathy  
 DUE TO, OR AS A CONSEQUENCE OF  
 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  
 (b)  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION  
 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  
 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH  
 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  
 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK  
 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  
 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Margie A. Koroll TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 2-10-87

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  
 23b. DATE 02/12/87  
 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery  
 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md

24. FUNERAL DIRECTOR NAME ADDRESS Dippel Funeral Homes, Inc. 7110 Belair Road Baltimore, MD 21206

25a. DATE REC'D. BY REGISTRAR FEB 11 1987  
 25b. REGISTRAR'S SIGNATURE Julien Anderson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201  
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and signed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | 8 7 0 3 8 5 6                                |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |  |   |  | REG. NO.                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>BESSIE PLOVSKY   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEB. 7, 1987           |  |  | 2b. HOUR A M<br>9:30 A M  |  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>MARCH 26, 1898   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>POLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                         |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>PIKESVILLE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MILFORD MANOR NURSING HOME |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MARYLAND BALTIMORE   |  | 13b. CITY OR TOWN<br>BALTIMORE   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br>4122 KENSHAW AVE. #21215                           |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>KASSIL KALANSKI   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>FAGA UNKNOWN |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>213-74-2240  |  | 17. INFORMANT ADDRESS<br>MR. JACK PLOVSKY 3939 CARTHAGE RD. 21133   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PNEUMONITIS<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 1a<br>ASCVD, ALZHEIMER'S DISEASE, OSTEOPOROSIS  |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (1) the hospital attended the deceased from 2/7/87 to 2/7/87, that (2) the deceased was above, (3) the deceased did not view the body after death, and that (4) my opinion death occurred on the date and hour and from the causes stated.   |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Howard B. Cohen  |  | DEGREE<br>ATTENDING PHYSICIAN  |  | MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED<br>2/7/87   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HOWARD B. COHEN   |  | 22e. ADDRESS<br>6610 CROSS COUNTRY BLVD  |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>2-9-87  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>RUDOMER VEREIN  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>ROSEDALE BALTO MD                            |  | 23e. ZIP CODE<br>21215  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.  
IMPORTANT: If item 21 is marked or item 28 shows any injury, or other trauma, a medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 8 7 0 3 8 5 7   |  | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph Aldney Poirier</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-3-1987</b>   |  | 2b. HOUR<br><b>3 P.M.</b>   |  |  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5-29-1912</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mass.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Balto. Co.</b> MD.                             |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1324 Glendale Rd.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Sales Mgr.</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Clothing</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b>  |  | 13b. COUNTY <b>Balto.</b>   |  | 13c. CITY OR TOWN <b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1811 Dunwoody Rd. 21234</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph N. Poirier</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katherine Leary</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-01-5448</b>  |  | 17 INFORMANT ADDRESS<br><b>Johanna Poirier, Same as 13e</b>  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE Cause (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Crown A disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>15 yr</u> |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22. I certify that (1) (this hospital) attended the deceased from <u>12/27</u> 19 <u>73</u> to <u>2/3</u> 19 <u>87</u> that (1) (we) last saw the deceased alive on <u>2/1/87</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>David A. Oursler</u>   |  |   |  | DEGREE<br><u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><u>2/4/87</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David A. Oursler, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>7401 Oursler Dr.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2-6-87</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Md.</b>                           |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc., 5305 Hartford Rd.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 6 1987</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>                                     |  |  |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA K Polinsky</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>15</b> YEAR <b>87</b> |   |  | 2b. HOUR<br><b>12a</b> M   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>01</b> YEAR <b>05</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Austria</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>St. Josephs Hospital</b>          |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <b>Penna.</b> CITY OR TOWN <b>Schuylkill</b>  |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13c. STREET ADDRESS<br><b>628 Altamont Blvd.</b>  |  | 13d. CITY OR TOWN<br><b>17931</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>Humphrey</b> MIDDLE <b>Kessock</b> LAST <b>Kathryn</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Kathryn</b> MIDDLE <b>Ryan</b> LAST <b>Ryan</b>            |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NAME UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.<br><b>168-14-4106</b>   |  |
| 17. INFORMANT<br><b>Mrs. Catherine Mullan</b>   |  | ADDRESS<br><b>21218 720 Gorsuch Ave.</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute C.H.F.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/6</b> 19 <b>87</b> , to <b>2/15</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2/15</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Nestor Carmichael</b>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22c. DATE SIGNED<br><b>2/15/87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NESTOR CARMICHAEL</b>   |  | 22e. ADDRESS<br><b>6014 Huford Rd., Balto., Md. 21218</b>                                       |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/18/87</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Asscension Oroth.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frackville Schuylkill Pa.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home Inc.</b>  |  | ADDRESS<br><b>1050 York Rd.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1987</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Deborah R. Randa</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be signed and checked.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |   |  |  |  | REG. NO. 03859   |  |
|--|--|--|---|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   |  |   |  |  |  | 7-7  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>HATTIE H. POLLOCK  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2-22-87 |   |  | 2b. HOUR<br>5 <sup>PM</sup>   |  |  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Mar. 5, 1891   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>95 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 8. IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Stella Maris Hospice |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Operator                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Switchboard                                     |  |  |  |
| 13a. STATE<br>MD   |  |  |   | 13b. CITY OR TOWN<br>Balto.   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br>6115 Fairdel Ave., 21206                           |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Henry Pollock   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Laura Macnamee  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |   | 16b. SOCIAL SECURITY NO.<br>212 09 5394   |  | 17. INFORMANT ADDRESS<br>Mrs. Barbara Kinnear, Same   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>RECENT STROKE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |   |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |   |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-10</u> , 19 <u>80</u> , to <u>2-22</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2-16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |  |   |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>DR. EDDIE NAKHUDA</u>   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>2-22-87</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. EDDIE NAKHUDA   |  |  |   | 22e. ADDRESS<br>STELLA MARIS HOSPICE  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2/25/87   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, MD  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |  |  |   |   |  | 25a. DATE REGD. BY REGISTRAR<br>FEB 24 1987   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia T. R. Rudeen                                     |  |  |  |

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(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 03860  
REG. NO.1- FOR  
STATE  
REGISTRAR

|  |  |   |  |  |   |  |   |   |  |
|--|--|---|--|--|---|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |   | 2a DATE OF DEATH   |  |   | 2b HOUR  |   |   |  |
| JOSEPH A POTRZUSKI   |  |   | 2 MONTH DAY YEAR<br>2 6 87   |  |   | 9:30 a.m.  |   |   |  |
| 3 SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH  |   | 6 AGE (IN YEARS LAST BIRTHDAY)   |   | 7 IF UNDER 1 YEAR   |  |
| Male   |  | White   |  | 9 - 24 - 1926  |   | 60 YRS.  |   | MONTHS DAYS HOURS MIN.  |  |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 9b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |   |  |
| Maryland   |  | U.S.A.  |  |  |   | BALTIMORE COUNTY MD.   |   |   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)              |   | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |
| TOWSON   |  | GREATER BALTIMORE MEDICAL CENTER  |  |  |   | Self Employed  |   | Tavern Owner  |  |
| 13a STATE  |  |   | 13b COUNTY   |  | 13c CITY OR TOWN                        |  | 13d INSIDE CITY LIMITS?   |   |  |
| Maryland   |  |   | Baltimore  |  | Dundalk                                 |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14 FATHER'S NAME   |  |   | 15 MOTHER'S MAIDEN NAME  |  |   | 13e STREET ADDRESS / ZIP CODE  |   |   |  |
| Adolph   |  |   | Josephine  |  |   | 6901 Fait Ave 21224  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT ADDRESS                    |  |   |   |  |
| Yes  |  |   | W.W.II   |  | 216-20-6901 Clara Potrzuski Same as 13e |  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of bladder</u>   |  |   |  |  |   |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |   |  |   |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |  |   |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |   |  |   |   |  |
| (c)  |  |   |  |  |   |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |   |  |  |   |  |   |   |  |
| 19a DATE OF OPERATION  |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a AUTOPSY?   |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?       |  |
| 2/1/87   |  |   | Acute arterial occlusion lt. leg   |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) |   |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |
|  |  |   |  |  |   |  |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>87</u> , to <u>2/6</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/5</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |  |   |   |  |
| 22b SIGNATURE  |  |   | DEGREE   |  |   |  |   | 22c DATE SIGNED   |  |
| <i>John E. Adams</i>   |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  |   | 2/6/87  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   | 22e ADDRESS  |  |   |  |   |   |  |
| JOHN E. ADAMS, M.D.  |  |   | 6701 N. Charles Street, Towson MD 21204  |  |   |  |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |   | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY       |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE                           |   |  |
| Cremation  |  |   | 2-9-87   |  | Westview Cemetery                       |  | Baltimore Maryland  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS  |  |   |  |  | 25a DATE REC'D. BY REGISTRAR            |  | 25b REGISTRAR'S SIGNATURE   |   |  |
| Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave Dundalk, Md. 21222  |  |   |  |  | FEB 9 1987                              |  | <i>John E. Adams</i>  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

WILKINSON

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NEW YORK 10017

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FOR  
STATE  
REGISTRAR

XC 17108417

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH


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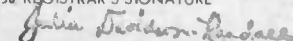
REG. NO.

03861

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN ROLAND POTTS</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 24, 1987</b>                              |   | 2b. HOUR<br><b>9:25A M</b>                                      |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 22, 1918</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.           |   |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FOREMAN - Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Landscaper</b>          |
| 13a. STATE<br><b>MARYLAND</b>  |   |   | 13b. COUNTY<br><b>ANNE ARUNDEL</b>   | 13c. CITY OR TOWN<br><b>PASADENA</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES E. POTTS</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE A. PORTER</b>                       |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b>  |  | 17. INFORMANT <b>William S. Potts</b> ADDRESS <b>20 S. Augusta Ave. 21229</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |   |   |

## MEDICAL CERTIFICATION

|  |  |  |
|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>SEVERE MALNUTRITION</b>   |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 22, 1986</b> , to <b>FEBRUARY 24, 1987</b> , that (I) (we) last saw the deceased alive on <b>FEBRUARY 24, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |
| 22b. SIGNATURE<br>  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>2-25-87</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C.V.J. VERGHESE, M.D.</b>  |  | 22e. ADDRESS<br><b>VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>                      |

|   |                             |  |   |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>2-28-87</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk. Cem.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>G. Truman Schwab</b>       |                             | 25a. DATE RECEIVED BY REGISTRAR<br><b>FEB 27 1987</b>                  | 25b. REGISTRAR'S SIGNATURE<br> |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified of office.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

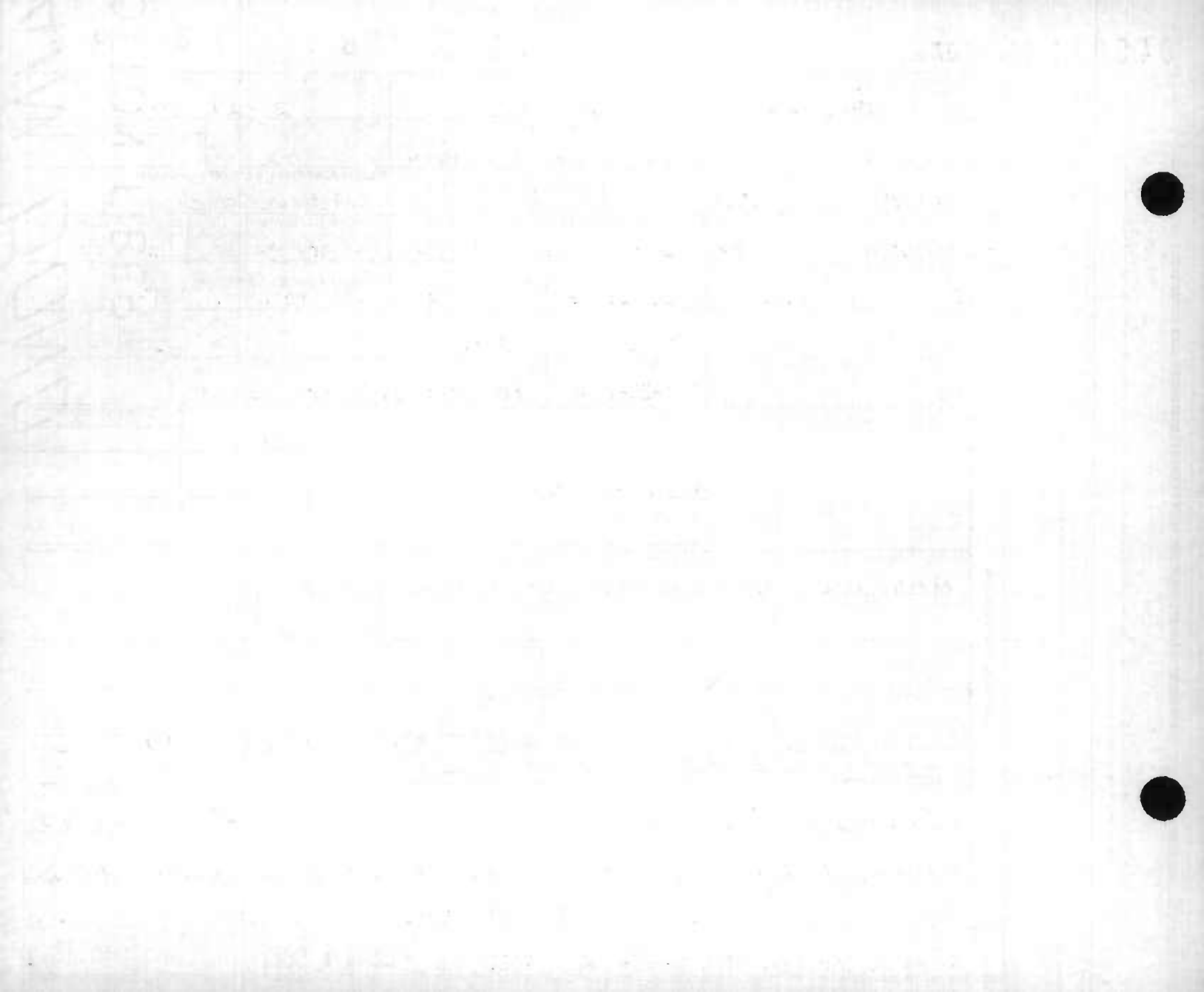
IMPORTANT: If item 24 is marked, item 18 (above) may be omitted.

DHMH - 16 60M 7/84  
(VRA 15, 4)

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |               | REG. NO. 87 03862   |  |
|--|--|--|--|---|--|--|--|--|---------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elizabeth F. Powers   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2-21-1987   |  |  | 2b. HOUR<br>M |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>04-25-1914  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |               | IF UNDER 24 HRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |               |   |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Factory Worker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Industry  |               |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  | 13b. COUNTY<br>A.A.  |  | 13c. CITY OR TOWN<br>Glen Burnie  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>118 Crest Rd. 21061                                |               |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alexander W. Sawyer  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Rysted  |  |  |  |  |               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>092-20-7585   |  | 17. INFORMANT<br>ADDRESS<br>Frederick T. Powers, same as 13   |  |  |  |  |               |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-Pulmonary arrest.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Aspiration.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |  |  |  |               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Angina; Old Cerebral Vascular accident.</u>   |  |  |  |   |  |  |  |  |               |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |               | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |               |   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |               |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-21</u> , 19 <u>87</u> , to <u>2-21</u> , 19 <u>87</u> , that (I) (we) lost<br>saw the deceased alive on <u>2-21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |               |   |  |
| 22b. SIGNATURE<br><u>Allen J. Chircus M.D.</u>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>2-21-87</u>   |               |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Allen J. Chircus M.D.</u>  |  |  |  |   |  | 22e. ADDRESS<br><u>Balt. County General Hosp.</u>  |  |  |               |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>24 Feb. 87  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Sepulchre Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>New Rochelle N.Y.  |  |  |               |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>James S. Kirkley, Glen Burnie, MD 21061  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 24 1987   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John F. ...</u>                                     |               |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |   |  | REG. NO. 87 03863  |  |
|---|--|---|--|---|--|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LEWIS FRANKLIN PRICE</b><br><b>LEWIS F. PRICE</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Feb 3, 1987</b>                         |  |   | 2b. HOUR<br><b>4:35a.m.</b>                               |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April, 24, 1909</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                  |   | 7. IF UNDER 1 YEAR IF UNDER 24 HRS                        |  |  |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self employed</b> |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  |   | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Phoenix</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Bacon Price</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susie Hoover</b>           |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   |  |   | 16b. SOCIAL SECURITY NO.<br><b>198-05-8866</b>                                 |  | 17. INFORMANT ADDRESS<br><b>Edith L. Price - same as #13c</b>                 |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial infarct with shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute cholecystitis</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |   |  |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 weeks</b> |  |
|   |  |   |  |   |  |  |   |   |  | <b>12/25/86</b>  |  |
|   |  |   |  |   |  |  |   |   |  | <b>12/22/86</b>  |  |
|   |  |   |  |   |  |  |   |   |  |  |  |
| MEDICAL CERTIFICATION   |  |   |  |   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>12/26</b> , 19 <b>86</b> , to <b>2/3</b> , 19 <b>87</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/2/87</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.   |  |   |  |   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Alan B. Cohen</b>  |  |   |  |   | DEGREE<br><b>MD</b>  |  |   | 22c. DATE SIGNED<br><b>2/3/87</b>                         |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alan B. Cohen</b>   |  |   |  |   | 22e. ADDRESS<br><b>201 E Univ. PKwy Balto Md. 21218</b>                        |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>2-6-87</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Jessop Methodist</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Balto. Md.</b> |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |  |   |  |   | ADDRESS<br><b>Towson, Md. 21204</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1987</b>                            |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |

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043874 FEB 13 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8703864  
REG. NO.

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
Gustie **ANASTASIA** Przybylski

2a. DATE OF DEATH MONTH DAY YEAR  
February 9, 1987

2b. HOUR  
2:45 p.m.

3. SEX  
Female

4. RACE  
CAUC.

5. DATE OF BIRTH MONTH DAY YEAR  
04 - 18 - 93

6. AGE (IN YEARS LAST BIRTHDAY)  
93

7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
MARYLAND

7b. CITIZEN OF WHAT COUNTRY?  
USA.

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
BALTIMORE Co. MD.

10. CITY OR TOWN OF DEATH  
Towson

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Dulaney Towson Nursing Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
HOMEMAKER

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE

13d. INSIDE CITY LIMITS?  
YES ☒ NO

13e. STREET ADDRESS / ZIP CODE  
716 S. GLOVER ST. 21224

14. FATHER'S NAME FIRST MIDDLE LAST  
MICHAEL ZAMENSKI

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
STANISLAWA

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO

16b. SOCIAL SECURITY NO.  
315-07-9851

17. INFORMANT ADDRESS  
MRS. ELEANOR GENTILE 716 S. GLOVER ST. 21224

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Cardiac Arrest  
DUE TO, OR AS A CONSEQUENCE OF (b) ASCD  
DUE TO, OR AS A CONSEQUENCE OF (c) Sudden  
Approximate interval between onset and death: 5 ± yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?  
YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT HOME

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 29 January 19 85 to 9 February 19 87, that (I) ~~was~~ last saw the deceased alive on 7 February 19 87, and that in my ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I ~~was~~ did not view the body after death.)

22b. SIGNATURE OF PHYSICIAN [Signature] ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED  
2/10/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL  
BURIAL

23b. DATE  
2/13/87

23c. NAME OF CEMETERY OR CREMATORY  
ST. STANISLAUS CEM. BALTIMORE

23d. LOCATION CITY OR TOWN COUNTY STATE  
BALTIMORE MARYLAND

24. FUNERAL DIRECTOR (NAME)  
Kaczorowski F. HOME 2525 FLEET ST.

25a. DATE REC'D. BY REGISTRAR  
FEB 11 1987

25b. REGISTRAR'S SIGNATURE  
[Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then page 4, remove carbon pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEMORANDUM

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

045662 MAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 03865

1- FOR  
STATE  
REGISTRAR

|  |  |                  |                |   |  |  |   |   |                               |   |                               |  |  |   |                            |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
|--|--|------------------|----------------|---|--|--|---|---|-------------------------------|---|-------------------------------|--|--|---|----------------------------|--|--|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>Jesse |   |  | MIDDLE<br>Roe  |   |   | LAST<br>Radcliffe, Jr.        |   |                               | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED XX 2-22 1987   |  |   | 2b. HOUR<br>M 5:15<br>P.M. |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 3. SEX<br>male   |  | 4. RACE<br>black |                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 13 41  |  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>45 YRS. |   | IF UNDER 1 YR.<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN |  | 7c. DATE<br>PRONOUNCED<br>DEAD 2-23 1987 |   |                            | 7d. HOUR<br>M 5:15<br>P.M.                         |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>MD   |  |                  |                | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                               |   |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.  |  |   |                            |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cockeysville  |  |                  |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>14102 Cuba Road |  |  |   |   |                               |   |                               | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>SANITATION                             |  |   |                            | 12b. KIND OF BUSINESS<br>OR INDUSTRY               |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 13a. STATE<br>Md   |  |                  |                | 13b. COUNTY<br>Balto  |  |  |   | 13c. CITY OR TOWN<br>COCKEYSVILLE   |                               |   |                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>14102 CUBA RD. 21030 |                            |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JESSE ROE  |  |                  |                |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RUTH JOHNSON  |   |   |                               |   |                               | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO                                |  |   |                            |  |  | 16b. SOCIAL SECURITY NO.<br>213423253           |  |  |  |  |  | 17. INFORMANT<br>JESSE R. RADCLIFFE, SR. 14102 CUBA RD. |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Dilated Hypertrophic Cardiomyopathy<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                  |                |   |  |  |   |   |                               |   |                               |  |  |   |                            |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |  |  |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |  |                  |                |   |  |  |   |   |                               |   |                               |  |  |   |                            |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |                |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |   |   |                               |   |                               |  |  |   |                            | 20. AUTOPSY?<br>YES XX NO <input type="checkbox"/> |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |                |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |   |   |                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                               |  |  |   |                            |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |                |   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) |   |   |                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                               |  |  |   |                            |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from Natural causes <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |                |   |  |  |   |   |                               |   |                               |  |  |   |                            |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| ACTUAL<br>SIGNATURE<br>Dennis F. Smyth, M.D.   |  |                  |                |   |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER                  |   |   |                               |   |                               | DATE SIGNED 2-24-87  |  |   |                            |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                  |                |   |  | ADDRESS 111 Penn St., Balto., Md. 21201                        |   |   |                               |   |                               |  |  |   |                            |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |                | 23b. DATE<br>2/28/87  |  |  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Church Cemetery   |                               |   |                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>COCKEYSVILLE   |  |   |                            |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  |                  |                |   |  | ADDRESS<br>1101 E. North Avenue                                |   |   |                               |   |                               | 25a. DATE RECEIVED BY REGISTRAR'S SIGNATURE<br>FEB 27 1987 Julia Sanders-Rodden MD                         |  |   |                            |  |  |   |  |  |  |  |  |   |  |  |  |  |  |

MEDICAL CERTIFICATION

GREEN-MOTCO-NO.2

044269 FEB 17 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 03866  
REG. NO.

|  |   |   |   |  |  |  |  |  |
|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | 2a. DATE OF DEATH   |  |  | 2b. HOUR   |  |  |
| James Hesson RANSEL  |   |   | February 15, 1987   |  |  | 9:00P M  |  |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE  |  |  | 7. IF UNDER 1 YEAR   |  |  |
| Male   | White   | Dec 12, 1901  | 85 YRS.   |  |  | MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| Pennsylvania   | U.S.A.  |   | Baltimore County, MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |
| Elmwood  | 409 Walcott Road 21206  |   | Labor Force   |  |  | Steel Co.  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   | 13b. INSIDE CITY LIMITS?  |  |  | 13c. STREET ADDRESS  |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 409 Walcott Road 21206   |  |  |
| 14. FATHER'S NAME  |   |   | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |
| James Ransel   |   |   | Philomenia Ondrizek   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |   |   | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT ADDRESS  |  |  |
| No   |   |   | 212-05-6928   |  |  | James M. Ransel 8420 B7 Kings Ridge Rd 21234                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Atherosclerosis, Coronary vessels disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>E left sided cereb. vascular accident</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>2 wks.</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><i>Emphysema, Sweet's disease, arthritis.</i>  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |
|  |   |   |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 2-15-1987, that (I) (we) last saw the deceased alive on 2-15-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE   |   |   |   | DEGREE   |  | 22c. DATE SIGNED   |  |  |
| John C. Hyle, M.D.   |   |   |   | M.D.   |  | 02/16/87   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   |   |   | 22e. ADDRESS   |  |  |  |  |
| John C. Hyle, M.D.   |   |   |   | 7527 Belair Road Baltimore, MD 21236   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |  |
| Burial   |   | Feb 19, 87  |   | Gardens OF Faith Cem.  |  | Baltimore Co., MD.   |  |  |
| 24. FUNERAL DIRECTOR   |   |   |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |
| The Dippel Funeral Homes, Inc.<br>7110 Belair Road Baltimore, Maryland 21206   |   |   |   | FEB 17 1987  |  | John C. Hyle, M.D.   |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove and retain this certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

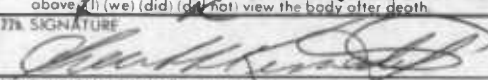
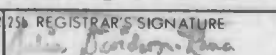
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

VIT  
Date Recd BAJ+  
The 1st of June

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The transit permit must be removed from the certificate, and the certificate must be removed from the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | REG. NO. 87 03867                            |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)<br>George RAYBON, SR.   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 8, 1987  |  |  |  | 2b. HOUR<br>5:20A <sub>M</sub>               |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>March 28, 1902  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS   |  | 7b. UNDER 24 HRS.<br>HOURS MIN.              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Romania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Journeyman   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Moving Co.  |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Dundalk   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | 13e. STREET ADDRESS / ZIP CODE<br>862 Jeanette Ave. 21222  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Michael Raybon  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sophia Not Known   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>195-07-4304  |  | 17. INFORMANT ADDRESS<br>Helen Gould 862 Jeanette Ave. 21222   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cranial meningioma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><u>Diabetes, Seizure disorder, Severe decubiti</u>  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 26, 1987</u> to <u>February 8, 1987</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>February 8, 1987</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>  |  |  |  | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>2/8/87   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Grace Kennedy, MD   |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2-12-87   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Jesus  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Duda-Ruck Funeral Home of Dundalk<br>7922 Wise Ave. Dundalk, MD 21222   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 17 1987   |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |  |  |  |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 03868  
REG. NO.

| FOR<br>STATE<br>REGISTRAR  |  |   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR  |  |  |  | 2b. HOUR |  |
|--|--|---|--|---|--|--|--|--|--|--|--|----------|--|
| FIRST MIDDLE LAST  |  |   |  | Thelma Reese  |  |  |  | Feb. 20-1987   |  |  |  | 7P M     |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |          |  |
| female   |  | White   |  | Oct 3 1903  |  | 83 YRS   |  |  |  |  |  |          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |          |  |
| Maryland   |  | USA.  |  |   |  | Baltimore County MD.   |  |  |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |  |
| Baltimore  |  | 14908 Ross Rd   |  |   |  |  |  | Housewife  |  |  |  |          |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. STREET ADDRESS / ZIP CODE   |  |  |  |          |  |
| 13a. MI.   |  |   |  | Carroll   |  | Millers  |  | 3924 Falls Rd. 21107   |  |  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |  |  |  |  |  |          |  |
| Daniel P. Miller   |  |   |  | Savallah Rhule  |  |  |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT<br>ADDRESS   |  |  |  |  |  |          |  |
| NO   |  |   |  | 214-05-3699 (4821 Falls Rd.)  |  | Caroline Ingram<br>21107   |  |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>15 yrs</u><br><u>10 yrs</u> |  |   |  |   |  |  |  |  |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>aneurysm internal carotid arteries</u>  |  |   |  |   |  |  |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED:<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 20</u> , 19 <u>88</u> , to <u>Feb 20</u> , 19 <u>87</u> , that (I, we) last saw the deceased alive on <u>12/30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I, we) did not view the body after death.  |  |   |  | 22b. SIGNATURE<br>W H FORD MD   |  |  |  | 22c. DATE SIGNED<br>2/20/87  |  |  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS  |  |  |  |  |  |  |  |          |  |
| W H FORD MD  |  |   |  | 3223 Main St Box 5<br>Manchester MD 21102   |  |  |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |          |  |
| Burial   |  |   |  | 02/24/87  |  | Black Rock Church  |  | Brodecks York pa.  |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   |  | 25a. DATE OF REGISTRATION<br>FEB 25 1987  |  |  |  |  |  |  |  |          |  |
| Eline Funeral Home<br>Hampstead Md.  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Jana Gordon-Rodney  |  |  |  |  |  |  |  |          |  |



4

045069 FEB 25 1987

1-  
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 03869

|   |  |                     |                           |  |  |   |   |   |  |                                      |  |  |   |  |                         |   |  |  |  |
|---|--|---------------------|---------------------------|--|--|---|---|---|--|--------------------------------------|--|--|---|--|-------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Gloria</b>   |  |                     | FIRST                     |  |  | MIDDLE  |   |   | LAST <b>Rehmer</b>   |                                      |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2 17 1987</b> |   |  | 2b. HOUR <b>1:18 PM</b> |   |  |  |  |
| 3 SEX <b>Female</b>   |  | 4 RACE <b>White</b> |                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>8/7/22</b>   |  |   | 6 AGE (IN YEARS LAST BIRTHDAY) <b>64 YRS.</b> |   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN |  |  | 7c. DATE PRONOUNCED DEAD <b>2 17 1987</b> |  |                         | 7d. HOUR <b>1:18 PM</b>                           |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>                                       |  |                     |                           | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO COUNTY</b> MD.   |   |  |                         |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                     |                           | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County Gen. Hospital</b> |  |   |   |   |  |                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeper</b>                         |   |  |                         | 12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b> |  |  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |                     |                           |  |  |   |   |   |  |                                      |  |  |   |  |                         |   |  |  |  |
| 13a. STATE <b>Md.</b>   |  |                     | 13b. COUNTY <b>Balto.</b> |  |  | 13c. CITY OR TOWN <b>Woodlawn</b>                                   |   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |  | 13e. STREET ADDRESS <b>7253 Fairbrook Rd. 21207</b>  |   |  |                         |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Earnest Rehmer</b>                                    |  |                     |                           |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Lillian Harvey</b> |   |   |  |                                      |  |  |   |  |                         |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>                 |  |                     |                           | 16b. SOCIAL SECURITY NO. <b>---</b>  |  |   |   | 17. INFORMANT ADDRESS <b>Rd., 21093</b>   |  |                                      |  |  |   |  |                         |   |  |  |  |
|   |  |                     |                           |  |  |   |   |   |  |                                      |  | 17. INFORMANT <b>Dr. Joseph F. McLaughlin, 2116 Woodfork</b>   |   |  |                         |   |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|   |  |  |  |   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>              |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |  |  |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE **E.P. Williamson** TITLE (SPECIFY) **M.D. Deputy** MEDICAL EXAMINER DATE SIGNED **2-17-87**

EXAMINER'S NAME (TYPE OR PRINT) **E.P. Williamson** ADDRESS **5550 BALTO MARL PK 21228**

|  |  |                          |  |  |  |  |  |
|--|--|--------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                  |  | 23b. DATE <b>2/19/87</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mays Chapel Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Balto., Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>J. E. Lowell Lemmon</b> ADDRESS <b>10 W. Padonia RD.</b> |  |                          |  | 25. DATE REC'D. BY REGISTRAR <b>FEB 24 1987</b>                |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>           |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

20% COTTON FIBRE

UNION MILLS LTD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please place this certificate in the container for the deceased's remains. IMPORTANT: If item 21 is marked as "injury," the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |   |  |   |   |   |   |
|---|--|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Norman H RENSCHAW  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 15, 1987 |   |   | 2b. HOUR<br>10:44P<br>M   |   |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOV. 28 1932  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54<br>YRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County<br>MD                                  |   |
| 10. CITY OR TOWN OF DEATH<br>Rossville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Electronic Circuits Inc.    |   |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Middle River   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alvin S. Renschaw   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elsie Briel  |  | 16. SOCIAL SECURITY NO.<br>212-30-1965  |   |   |   |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 17b. KOREAN<br>Korean   |  | 17c. INFORMANT ADDRESS<br>Frances Renschaw 1531 Chilworth Ave.  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                      |  |   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 9, 1987, to February 15, 1987, that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on February 15, 1987, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |   |   |   |   |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert KASS MD.,   |  |   |  | 22c. DATE SIGNED<br>2/16/87   |   | 22d. ADDRESS<br>9000 Franklin Square Dr., 21237   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>2/19/87  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Middle River Balto. Md.                           |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Connelly Funeral Home   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 18 1987  |   | 25b. REGISTRAR'S SIGNATURE<br>John Benson-Rudman  |   |

3

043186 FEB 3 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87

REG. NO.

03871

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>BERNARD J. RETZ</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02 01 87</b> |   |  | 2b. HOUR<br><b>0415A</b>   |   |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 22 17</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. COUNTY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b>  |   |
|   |  |   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TIRE CO.</b>   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |   |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN RETZ</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KATHERINE SCHULTE</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>AGNES RETZ (WIFE) SAME ADDRESS</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC COMPLICATIONS</b>   |  |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |   |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>PARTIAL LARYNGECTOMY FOR LARYNGEAL CANCER</b>   |  |   |  |   |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>It was last seen by Dr. John T. H. Jr. in cancer remission then</b>   |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) _____ the body after death. |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>[Signature]</b> M.D.   |  |   |  | DEGREE  |  | 22c. DATE SIGNED<br><b>3/1/87</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Murphy, George</b>  |  |   |  | 22e. ADDRESS<br><b>1212 York Road Lutherville, Md 21093</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>2/2/87</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Schluenck Funeral Home, Inc.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |   |  |  |   |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

FEB 3 1987

3/1/2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other cause, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 3 8 7 2

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ELVA MAE RICHARDSON   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 19, 1987                          |  | 2b. HOUR<br>11:08 M. A.M.  |
| 3 SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>February 4, 1909  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS                                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>310 Lambeth Rd. Catonsville, Md. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| 13a. STATE<br>Maryland  |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Catonsville   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          | 13e. STREET ADDRESS / ZIP CODE<br>316 Lambeth Rd. Catonsville, Md. 21228   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry F. Conrades   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edna M. Imhoff   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----  | 12. INFORMANT<br>ADDRESS<br>Md. 21228<br>Joan Mae Gaffney 310 Lambeth Rd. Catonsville,  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr<br>4 hr                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death.)             |   |   |  |  |  |
| 22b. SIGNATURE<br>  |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>2/19/87  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Raymond D. Bahr  |   | 22e. ADDRESS<br>St. Agnes Medical Center, Baltimore, MD.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>2/ 24/87   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland               | 24. FUNERAL DIRECTOR<br>Leroy M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, MD. 21228 |  |
| 25a. DATE REC'D. BY REGISTRAR<br>FEB 25 1987  |   | 25b. REGISTRAR'S SIGNATURE<br>  |  |  |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE MD. 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

17 DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

PHILLIP

ARTHUR

RIPPEL

2a. DATE KNOWN  
OF DEATH ESTI-  
MATED ☒ MONTH DAY YEAR

2-7-87 19

2b HOUR

M

3 SEX

Male

4 RACE

White

5. DATE OF BIRTH

11 20 1961

6 AGE (IN YEARS  
LAST BIRTHDAY)

25 YRS.

IF UNDER 24 HRS.

MONTHS DAYS HOURS MIN.

2c. DATE  
PRONOUNCED  
DEAD

2-7-87 19

2d HOUR

3:15A

7. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County

MD.

10. CITY OR TOWN OF DEATH

Dundalk

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Merritt Blvd. @ Old North Point Rd.

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS  
OR INDUSTRY

AT&amp;T

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE

Maryland

13c. COUNTY

Baltimore

13d. CITY OR TOWN

Essex

13e. INSIDE CITY LIMITS?

YES ☐ NO ☒

13f. STREET ADDRESS

1206 Rickenbacker Rd. 21221

14. FATHER'S NAME

John

W.

Rippel Jr.

15. MOTHER'S MAIDEN NAME

Dixie

R.

Lawson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

yes

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

17. INFORMANT

ADDRESS

John Rippel III 6918 Fenway Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple injuries

8120

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

2:28A. 2-7-87 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

apparently the driver of a car which struck

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

hwy.

the rear of a tractor trailer

Merrit Blvd. @ Old North Pt. Blvd. Baltio. Co., Md.

22a. I certify that I took charge of the remains described above, held an

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

Margarita A. Korell

TITLE (SPECIFY)

M.D. Assistant

MEDICAL EXAMINER

DATE SIGNED 2-7-87

EXAMINER'S NAME  
(TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS

111 Penn Street

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

2/10/1987

23c. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

23d. LOCATION  
CITY OR TOWN

Baltimore, Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

Connelly Funeral Home of Dundalk

25a. DATE REC'D. BY REGISTRAR

FEB 13 1987

25b. REGISTRAR'S SIGNATURE

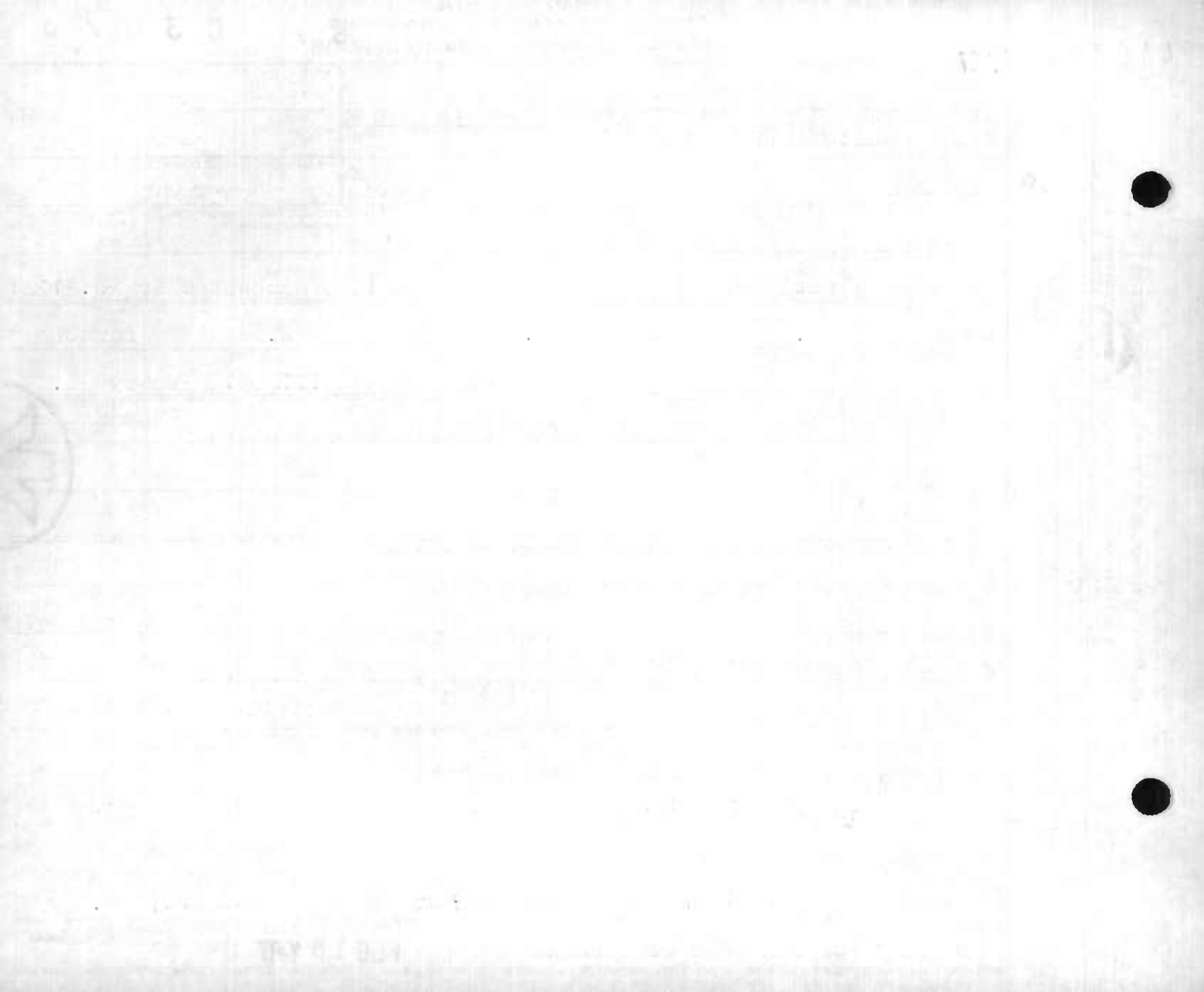
John Anderson-Randall

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove caution paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 3 8 7 4  
REG. NO.

|  |  |  |  |   |  |   |  |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Hazel JoAnn Roark</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 7 87</b> |   |  | 2b. HOUR<br>M<br><b>M</b>   |  |  |   |  |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 13 34</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>    |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b> |  |
| 7a. BIRTHPLACE (COUNTRY)   STATE OR FOREIGN<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3250 Ryerson Circle (Home)</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Legal Secretary</b>      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Law</b> |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3250 Ryerson Circle 21227</b>   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Burnett Roark</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruby Rebecca Wallen</b>   |  |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-32-5918</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mary C. Scanlon Same as 13e</b>  |  |   |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic breast carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> |  |  |  |   |  |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |  |  |   |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |   |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>86</u> , to <u>Feb</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Richard Nora</u> MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>2/9/87</u>  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD NORA</b>   |  |  |  | 22e. ADDRESS<br><b>UNIV OF MARYLAND CANCER CENTER</b>   |  |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/10/87</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>                               |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce</b>   |  |  |  | ADDRESS<br><b>4001 Ritchie Hgwy Balto Md</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 09 1987</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia D. Anderson</u>   |   |  |  |  |



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                 |  |   |  |   |  |  |  |   |  | REG. NO. 03875  |  |   |  |                                    |  |  |  |
|--|--|---------------------------------|--|---|--|---|--|--|--|---|--|---|--|---|--|------------------------------------|--|--|--|
| 1- STATE REGISTRAR   |  |                                 |  |   |  |   |  |  |  |   |  |   |  |   |  |                                    |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Phyllis E. Roberts</b>   |  |                                 |  |   |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH MATED <b>February 24 1987</b>                               |  |   |  |                                    |  |  |  |
| 2b. SEX <b>female</b>  |  | 4 RACE <b>caucasian</b>         |  | 5 DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>8</b> YEAR <b>16</b>   |  | 6 AGE (IN YEARS)<br>LAST BIRTHDAY <b>70</b> YRS.  |  | IF UNDER 1 YR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b>                                       |  | 7c. DATE PRONOUNCED DEAD <b>February 24 1987</b>                                    |  | 7d. HOUR <b>12:37</b>   |  |                                    |  |  |  |
| 1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                 |  |   |  |                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  |                                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>homemaker</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |                                    |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b> |  | 13c. CITY OR TOWN<br><b>Timonium</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  | 13e. STREET ADDRESS<br><b>2113 Sweetbrier Lane 21093</b>   |  |   |  |   |  |   |  |                                    |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>A. Elmer</b> MIDDLE <b></b> LAST <b>Erdman</b>   |  |                                 |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Jessie</b> MIDDLE <b></b> LAST <b>Hayne</b>                              |  |  |  |   |  |   |  |   |  |                                    |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>   |  |                                 |  | 16b. SOCIAL SECURITY NO.<br><b>216 09 7206</b>  |  | 17. INFORMANT<br><b>Carole H. Roberts</b> ADDRESS <b>Westminster, Md. 21157</b><br><b>138 1/2 Liberty St.</b> |  |  |  |   |  |   |  |   |  |                                    |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral aneurysm</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>ASCD</b><br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |                                 |  |   |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>2+ yr</b> |  |                                    |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                                 |  |   |  |   |  |  |  |   |  |   |  |   |  |                                    |  |  |  |
| 19a. DATE OF OPERATION   |  |                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |                                    |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |   |  |   |  |                                    |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |   |  |                                    |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                 |  |   |  |   |  |  |  |   |  |   |  |   |  |                                    |  |  |  |
| ACTUAL SIGNATURE <b>Charles Erdman</b> M.D. TITLE SPECIFY <b>Deputy</b>  |  |                                 |  |   |  |   |  |  |  |   |  | DATE SIGNED <b>2/24/87</b>  |  |   |  |                                    |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |                                 |  |   |  |   |  |  |  |   |  | ADDRESS   |  |   |  |                                    |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>cremation</b>  |  |                                 |  | 23b. DATE<br><b>2/27/87</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery Co.</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore City</b> COUNTY <b></b> STATE <b>Md.</b> |  |   |  |   |  |                                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Gary L. Kaufman</b> ADDRESS <b>5695 Main St., Elkridge, Md. 21227</b>  |  |                                 |  |   |  |   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1987</b>                                    |  |   |  | 25b. REGISTRAR'S SIGNATURE <b></b> |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 7 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8703876

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |   |  |   |  |  |
|--|--|--|---|--|--|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Miriam Smiley Robider  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 16 1987                    |  |  | 2b HOUR<br>1:20 P M   |  |   |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>July 1895   |  | 6 AGE (IN YEARS (LAST BIRTHDAY))<br>91 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Georgia  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br>Parkville  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Valley View Nursing Home |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Registered Nurse |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Medical   |  |  |
| 13a STATE<br>Maryland  |  |  | 13b COUNTY<br>Baltimore   |  | 13c CITY OR TOWN<br>Cockeysville   |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e STREET ADDRESS / ZIP CODE<br>10114 Charington Rd., 21030 |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Robider   |  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Fannie Silverberg  |  |   |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No -  |  |  | 16b SOCIAL SECURITY NO.<br>217-30-4256                                |  | 17 INFORMANT<br>ADDRESS<br>Doris K. Stadler, 10114 Charington Rd., 21030   |   |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Severe arteriosclerotic cardiovascular disease 10 yrs</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u> |  |  |   |  |  |   |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><u>h/o CVA, NIDDM, Recurrent UTI's, h/o Haddes CA</u>  |  |  |   |  |  |   |  |   |  |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |   |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |
| 21g I certify that (1) this hospital attended the deceased from <u>January 19 85</u> to <u>2/16</u> 19 <u>87</u> , that (2) (we) lost sight of the deceased <u>on or about</u> <u>2/16</u> 19 <u>87</u> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) not see the body after death.)   |  |  |   |  |  |   |  |   |  |  |
| 22a SIGNATURE<br><u>Alicia A. Cool-Foley</u>   |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c DATE SIGNED<br><u>2/17/87</u>   |  |  |
| 22b PHYSICIAN'S NAME (TYPE OR PRINT)<br>Alicia A. Cool-Foley, M.D.   |  |  |   |  | 22e ADDRESS<br>Union Memorial Hospital - Suite 401   |   |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b DATE<br>2/18/87   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cem.  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville Balto. Md.                             |   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Martin D. Lawson  |  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br>FEB 18 1987  |   | 25b REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>                                     |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|  |  |  |  |   |                                  |
|--|--|--|--|---|----------------------------------|
| FOR<br>1 - STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |                                  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |                                  |
| FIRST MIDDLE LAST  |  | MONTH DAY YEAR   |  | M   |                                  |
| Eloise B. Robey  |  | February 18, 1987  |  |   |                                  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE   | 7. IF UNDER 1 YEAR  |                                  |
| F  | W  | MONTH DAY YEAR   | 84 YRS   | MONTHS DAYS   | HOURS MIN.                       |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |                                  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 11. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |                                  |
| Maryland   |  | Baltimore Co., MD.   |  |   |                                  |
| 12. CITY OR TOWN OF DEATH  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 15. KIND OF BUSINESS OR INDUSTRY |
| Towson   | St. Joseph Hospital  |  | Secretary  |   | Seed Co.                         |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 17. INSIDE CITY LIMITS?  |  | 18. STREET ADDRESS / ZIP CODE   |                                  |
| 13a. STATE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 5204 Belleville Ave. 21207  |                                  |
| Md.  |  |  |  |   |                                  |
| 19. FATHER'S NAME  |  | 20. MOTHER'S MAIDEN NAME   |  |   |                                  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |   |                                  |
| George N. Benson   |  | Fannie Leister   |  |   |                                  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 22. SOCIAL SECURITY NO.  |  | 23. INFORMANT ADDRESS   |                                  |
| No   |  | 212 09 0458A   |  | Mrs. Kathleen Benson 6904 Bellona Ave. -12  |                                  |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 25. IMMEDIATE CAUSE (a)  |  | 26. DUE TO, OR AS A CONSEQUENCE OF (b)  |                                  |
| PART I DEATH WAS CAUSED BY:  |  | Cardiac arrest   |  | ASCD  |                                  |
| 27. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.   |  | 28. DUE TO, OR AS A CONSEQUENCE OF (c)   |  | 5+yr  |                                  |
| 29. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                  |  |  |  |   |                                  |
| 30. DATE OF OPERATION  |  | 31. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 32. AUTOPSY?  |                                  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |
| 33. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)         |  | 34. TIME OF INJURY   |  | 35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)   |                                  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |   |                                  |
|  |  | P.M. 19  |  |   |                                  |
| 36. INJURY OCCURRED  |  | 37. PLACE OF INJURY  |  | 38. LOCATION  |                                  |
| 39. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]   |  | STREET CITY OR TOWN COUNTY STATE  |                                  |
| 40. I certify that (I) (this hospital) attended the deceased from  |  | 41. saw the deceased alive on  |  | 42. and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated |                                  |
| 17 Sept 19 82  |  | 15 Feb 19 87   |  | 18 February 19 87   |                                  |
| 43. SIGNATURE  |  | 44. DEGREE   |  | 45. DATE SIGNED   |                                  |
| Charles F. O'Connell   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 2/19/87   |                                  |
| 46. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 47. ADDRESS  |  |   |                                  |
|  |  |  |  |   |                                  |
| 48. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 49. DATE   |  | 50. NAME OF CEMETERY OR CREMATORY   |                                  |
| Burial   |  | 2/20/87  |  | Druid Ridge   |                                  |
| 51. FUNERAL DIRECTOR   |  | 52. DATE REC'D. BY REGISTRAR   |  | 53. REGISTRAR'S SIGNATURE   |                                  |
| NAME ADDRESS   |  |  |  |   |                                  |
| MITCHELL-WIEDEFELD HOME, INC.  |  | 6500 York Rd.  |  | FEB 25 1987 Julia T. ...  |                                  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene for statistical, legal, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>- STATE<br>REGISTRAR   |  |   |  |   |  |   |  |  |  |
| 2. REG. NO. 8703878  |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mary Lee ROCKS  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 25, 1987   |   |  | 2b. HOUR<br>3:45a M  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 8, 1919  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Middle River   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>201 Wampler Road 21220   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jessie Amos  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura Neeks   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>245 05 5035   |  | 17. INFORMANT<br>Albert Rocks   |  | ADDRESS<br>(same)   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Breast Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>February 9</u> , 19 <u>87</u> , to <u>February 25</u> , 19 <u>87</u> , that (we) last saw the deceased alive on <u>February 25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (she) (it) (we) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>DEGREE<br>THE PHYSICIAN'S NAME (TYPE OR PRINT)<br>Roger Moushabek, M.D.  |  |   |  |   | 22c. DATE SIGNED<br>02/25/87<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22d. ADDRESS<br>9000 Franklin Sq. Dr., 21237   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>2/28/87  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Mem. Gardens   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County Maryland                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>Brudzinski Funeral Home PA 1407 Old Eastern Ave.   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 25 1987   |   |  |  |  |
|  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Anderson   |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial. If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

by [redacted] 610 7041 [redacted] [redacted] [redacted] [redacted]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 8 7 0 3 8 7 9   |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>John Joseph Roddy  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 27 87  |  | 2b. HOUR<br>4 A M   |  |
| 3. SEX<br>M   |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 28 86  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                 |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Lumber   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>508 A Castle Dr. 21212  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Luke Roddy   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Margaret Tighe  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>137-03-0428   |  | 17. INFORMANT ADDRESS<br>Mrs. Catherine Roddy 508 A Castle Dr. 21212  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>CVA with 2 hemipareses.</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Adel S. El-Hennawy MD   |  | DEGREE<br>MD  |  |   |  | 22c. DATE SIGNED<br>2-27-87  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Adel S. El-Hennawy   |  |
| 22e. ADDRESS<br>SJH.  |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>3/2/87   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Mitchell-Wiedefeld   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 02 1987  |  | 25b. REGISTRAR'S SIGNATURE<br>John W. ...  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |   |  |  | REG. NO.<br>87 03880                         |  |
|--|--|---|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Harold L. Rodman</u>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>2-24-1987</u>  |   |   |  | 2b. HOUR<br><u>11:24am</u>   |  |  |
| 3. SEX<br><u>male</u>  |  | 4. RACE<br><u>white</u>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>4-26-1915</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>71</u> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                          |  | IF UNDER 24 HRS                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MARYLAND</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE COUNTY</u> MD.                             |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>RANDALLSTOWN</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>BALTIMORE COUNTY GEN. HOSP.</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>HYPNO-THERAPIST</u>      |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>HYPNOSIS</u>               |  |  |  |
| 13a. STATE<br><u>MARYLAND</u>  |  | 13b. COUNTY<br><u>BALTO.</u>  |  | 13c. CITY OR TOWN<br><u>BALTIMORE</u>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><u>7018 DEERFIELD RD. #21208</u> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>CHARLES RODMAN</u>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>ANNA BRILL</u>   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>YES</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>WWII-NAVY</u>  |  | 17. INFORMANT<br><u>MRS. ESTHER RODMAN</u>  |  | <u>7018 DEERFIELD RD. BALTO., MD</u>  |   |  |  | <u>21208</u>                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease.</u> |  |   |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-24-1987</u> , to <u>2-24-1987</u> , that (I) (we) lost<br>saw the deceased alive on <u>2-24-1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Allen J. Churchus M.D.</u>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br><u>2-24-87</u>                                 |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Allen J. Churchus</u>  |  |   |  |   | 22e. ADDRESS<br><u>Balt. County General Hosp</u>   |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>   |  |   | 23b. DATE<br><u>FEB. 26, 1987</u>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>PETACH TIKVAH</u>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>ROSEDALE BALTO. MD</u>   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>SOL LEVINSON &amp; BROS. INC.</u><br><u>6010 REISTERSTOWN RD. BALTO., MD 21215</u>  |  |   |  |   | 25a. DATE RECEIVED BY REGISTRAR<br>MAR 05 1987   |   |   |  |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03881  
REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | FEB 17, 1987  |  | 6 <sup>30</sup> A M   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))                                   |  |
| MALE   |  | WHITE  |  | 11 - 22 - 1899  |  | 87 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Pa.  |  | U.S.A.   |  |   |  | Baltimore County MD   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Catonsville  |  | 2535 Old Frederick Rd.   |  | Weaver  |  | W.S. Dicky  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Md.  |  | Baltimore  |  | Catonsville   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS / ZIP CODE  |  |   |  |
| John   |  | Reidenbaugh  |  | 2535 Old Frederick Rd. 21220  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |
| No   |  | 213-09-6052  |  | Loretta Mongold   |  | 760 Oella Ave. 21043  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiac vascular disease</u>   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |
| (b) _____  |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |
| (c) _____  |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
|  |  | P.M. 19  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION   |  |   |  |
|  |  |  |  | CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-5</u> 19 <u>87</u> , to <u>2-17</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2-16</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |   |  |
| Thomas F. Herbert, M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 2-17-87   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |
| Thomas F. Herbert, M.D.  |  | 3779 Church Rd. Ellicott City, Md 21043  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |
| Burial   |  | 2-20-87  |  | Good Shepherd Cem.  |  | Ellicott City Howard Md   |  |
| 24. FUNERAL DIRECTOR   |  | NAME   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  |
| Black Funeral Home   |  | Ellicott City, Md. 21043   |  | Box 268   |  | FEB 20 1987   |  |
|  |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |
|  |  |  |  |   |  | Julia Davidson-Randall  |  |

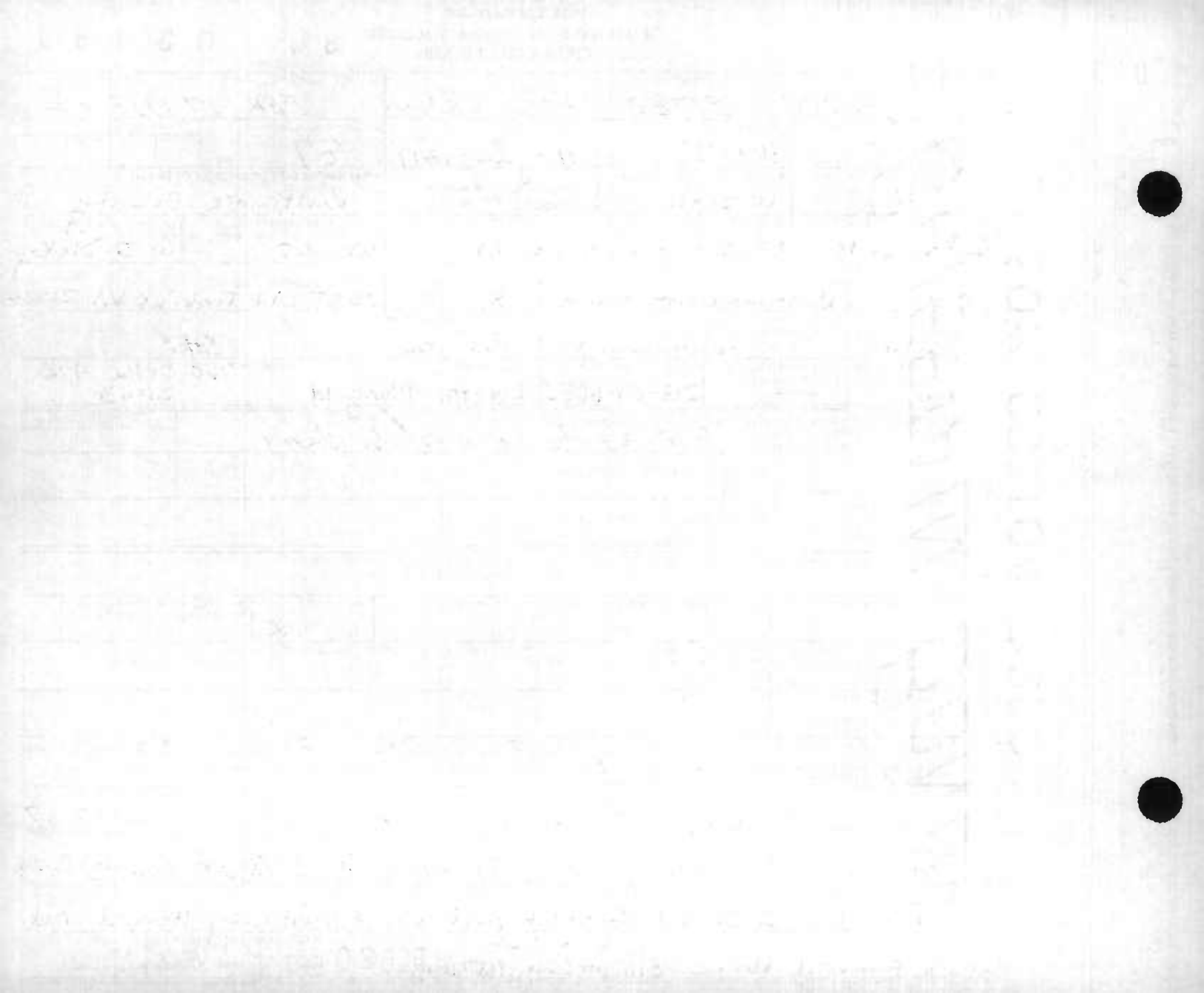
MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having been viewed, the medical examiner must be notified of entry.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03882  
REG. NO.

|  |   |  |   |  |   |
|--|---|--|---|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mr. Alphert F. Rohrbach</b>   |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 19 1987</b>  |   | 2b HOUR<br><b>21:35 M</b>  |   |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>Caucasian</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 6 1899</b>   |   | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>87</b>  |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                                 |   |
| 10 CITY OR TOWN OF DEATH<br><b>Randallstown</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b> |  | 12b KIND OF BUSINESS OR INDUSTRY                                |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>  |   | 13b COUNTY<br><b>Baltimore</b>   | 13c CITY OR TOWN<br><b>Woodlawn</b>   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE<br><b>8311 Dogwood Road 21207</b> |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Rohrbach</b>  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |   |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(NO OR UNKNOWN)<br><b>No</b>  |   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-10-0019</b>   |   | 17 INFORMATION<br>Mr. James Rohrbach ADDRESS<br><b>8311 Dogwood Road Baltimore Maryland</b>    |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute M.I.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>C.H.F.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)              |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |   |  |   |  |   |
| 19a DATE OF OPERATION  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a I certify that (if this hospital) attended the deceased from <b>2/19</b> 19 <b>87</b> , to <b>2/19</b> 19 <b>87</b> , that (we) lost<br>saw the deceased alive on <b>2/19</b> 19 <b>87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |  |   |  |   |
| 22b SIGNATURE<br><b>Young J. Ro M.D.</b>   |   | DEGREE<br><b>B. C. G. H.</b>   |   | 22c DATE SIGNED<br><b>2/19/87</b>  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e ADDRESS  |   |  |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b DATE<br><b>2/21/87</b>   |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Locust Valley Cemetery</b>                             |   |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc</b>  |   | 24b ADDRESS<br><b>8728 Liberty Road Randallstown, MD. 21133</b>  |   | 24c LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Middletown Frederick MD.</b>                   |   |
| 25a DATE REC'D. BY REGISTRAR<br><b>FEB 23 1987</b>   |   | 25b REGISTRAR'S SIGNATURE<br><b>Jane Davidson-Randall</b>  |   |  |   |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please affix the appropriate carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to transportation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 3 8 8 3

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Regina M. Rohrer</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 6, 1987</b>                       |   | 2b. HOUR<br>M<br><b>M</b>                        |
| 1. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 9, 1919</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Schuylkill, Penna.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rosedale 21237</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6004 Hamilton Ave.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |  |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Rossville</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jeremiah DeLay</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Gallagher</b>               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>175 01 9433</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Andrew Rohrer (same)</b>   |  |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Carcinoma of the Bronchus**

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)

**Diabetes mellitus**

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) <input checked="" type="checkbox"/> this hospital attended the deceased from <b>9/30/1986</b> to <b>2/6/1987</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>12/12/1986</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>D.H. Sherbourne</b>   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>2/7/87</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DH SHERBOURNE</b>  |  | 22e. ADDRESS<br><b>9101 FRANKLIN SQ Dr 21237</b>                       |  |  |  |

|  |                            |   |  |
|--|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Cremation</b>        | 23b. DATE<br><b>2/7/87</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Prudzinski Funeral Home</b>     |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 09 1987</b>               |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Tindem-Pedersen</b> |                            |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 0388

|   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Salvator ROMANIELLO</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 19, 1987</b>        |   |  | 2b. HOUR<br><b>12:20p</b>  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 17, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Factory Worker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Rosedale</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>5 Glenwest Court 21237</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Romaniello</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Del Buona</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-03-1462</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Lena Franklin same as 13e</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b>  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Complications of transitional cell cancer of kidney</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>February 9, 1987</b> to <b>February 19, 1987</b> that (X) (we) last saw the deceased alive on <b>February 19, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Roy Fontenot</i> DEGREE  |  |  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/19/87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Roy Fontenot</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Feb. 24, 1987</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Rosary Cemetery</b>              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dundalk Baltimore, MD</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1987</b>  |  | 25b. REGISTRAR'S SIGNATURE   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1. Name of the person or organization to whom the letter is addressed.  
2. Address of the person or organization to whom the letter is addressed.  
3. City, State, and Zip Code of the person or organization to whom the letter is addressed.  
4. Date of the letter.  
5. Salutation (e.g., Dear Sir, Dear Madam, Dear Mr. Smith).  
6. Body of the letter (the main text).  
7. Closing (e.g., Sincerely, Very truly yours, Respectfully).  
8. Signature of the person sending the letter.  
9. Name and Title of the person sending the letter.  
10. Address of the person sending the letter.



1. Name of the person or organization to whom the letter is addressed.  
2. Address of the person or organization to whom the letter is addressed.  
3. City, State, and Zip Code of the person or organization to whom the letter is addressed.  
4. Date of the letter.  
5. Salutation (e.g., Dear Sir, Dear Madam, Dear Mr. Smith).  
6. Body of the letter (the main text).  
7. Closing (e.g., Sincerely, Very truly yours, Respectfully).  
8. Signature of the person sending the letter.  
9. Name and Title of the person sending the letter.  
10. Address of the person sending the letter.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

870388  
REG. NO.

| 1. FOR<br>STATE<br>REGISTRAR  |  | 3. DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 7 0 3 8 8 5<br>REG. NO.   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
| Edna R ROUSE  |  |   |  | February 27, 1987   |  | 5:45 PM   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| FEMALE  |  | WHITE   |  | MONTH 10 DAY 22 YEAR 04   |  | 82 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| MARYLAND  |  | USA   |  |   |  | Baltimore County MD   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| ROSSVILLE   |  | FRANKLIN SQUARE HOSPITAL  |  | HOUSEWIFE   |  | HOMEMAKING  |  |
| 13a. STATE  |  |   |  | 13b. CITY OR TOWN   |  | 13c. STREET ADDRESS / ZIP CODE  |  |
| MARYLAND  |  |   |  | BALTIMORE   |  | 20 GREENWOOD AVE. 21206   |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |
| James A. Hooper   |  |   |  | Elizabeth A. Biddison   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS   |  |   |  |
| No  |  | 216-42-7364A  |  | Allen Rouse 20 Greenwood Ave. 21206   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cachexia, Malnutrition</u><br><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 20, 1987, to February 27, 1987, that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> saw the deceased alive on <input type="checkbox"/> above, <input checked="" type="checkbox"/> (we) (did) (do) not, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Kirk R. Steptoe MD</u>   |  |   |  | 22c. DATE SIGNED<br>2-27-87   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |
| Kirk Steptoe MD   |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| Burial  |  | 3-2-87  |  | Baltimore Cemetery  |  | Baltimore City, Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  | 25c. DATE REC'D. BY REGISTRAR   |  |
| F.H.  |  | 03 1987   |  | [Signature]   |  | 03 1987   |  |

*[Faint, mostly illegible text covering the majority of the page, possibly a memorandum or report.]*

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44624 FEB 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 03886  
REG. NO.

|  |  |  |   |  |                            |  |
|--|--|--|---|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Dorothy R. ROWLANDS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 16, 1987</b> |  | 2b. HOUR<br><b>8:13P M</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 30 1923</b>  |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.  |  | 7a. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 7b. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>63</b>   |                            |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   | 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |                            |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                            |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. CITY OR TOWN<br><b>Balto.</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>Essex</b> |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur S. Evans</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bernadette Fallon</b>  |   | 16. STREET ADDRESS / ZIP CODE<br><b>1826 Kitty Hawk Road 21221</b>   |                            |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 17b. SOCIAL SECURITY NO.<br><b>193-12-0093</b>   |   | 17. INFORMANT<br><b>Ann Louise Burger</b>  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial infarction</b>   |   | DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |   |  |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |                            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21a. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                               |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                            |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 1, 1987</b> to <b>February 16, 1987</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>February 16, 1987</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |   |  |                            |  |
| 22b. SIGNATURE<br><i>Alfred J. Covington</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2-16-87</b>   |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alfred J. Covington, MD</b>  |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>  |   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/19/87</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus Dundalk</b>                                   |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto, Maryland</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Connelly Funeral Home 300 Mace Ave. 21221</b>   |   |  |                            |  |
| 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |   |  |                            |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to interment, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above any injury or other traumatic event, the medical examiner must be notified at once.

BP



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043644 FEB 11 1987

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 03887  
REG. NO.

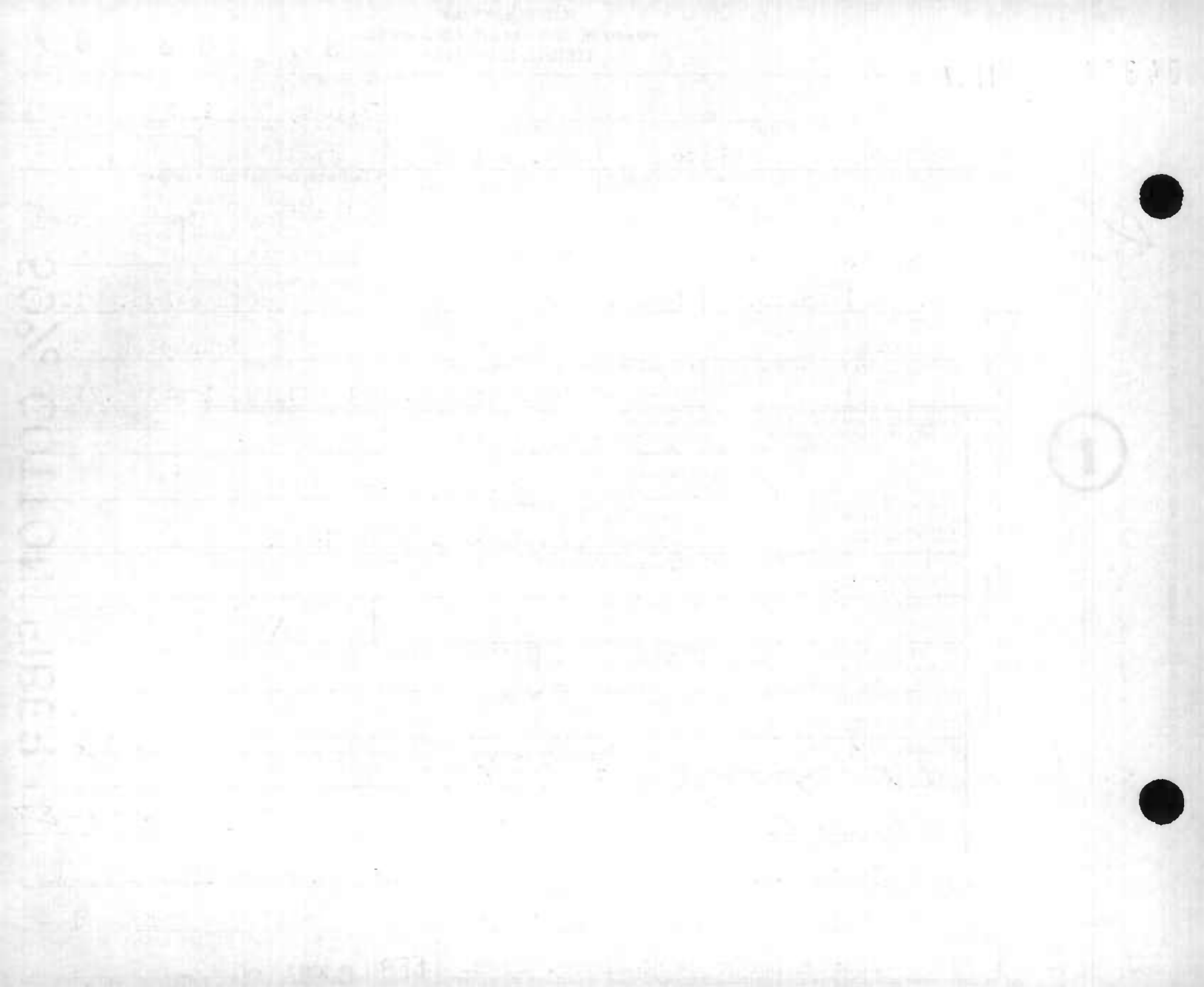
|  |  |  |  |   |                                  |  |  |
|--|--|--|--|---|----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Stella F RUIL</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 4, 1987</b> |   | 2b. HOUR<br>P M<br><b>2:45 P</b> |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 9 1923</b>  |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> *EVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife.</b>                                      |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>MiddleRiver</b>   |                                  | 13d. STREET ADDRESS / ZIP CODE<br><b>1303 Fuselage Ave. 21220</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anne Schubelek</b>  |                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>209-18-2018</b>   |  | 17. INFORMANT ADDRESS<br><b>Petrus C. Ruil 1303FuselageAve.21220</b>  |                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>DECOMPENSATED CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>UNCONTROLLED HYPERTENSION, AORTIC STENOIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |  |  |   |                                  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>CHRONIC RENAL FAILURE</b>   |  |  |  |   |                                  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 26, 1987</b> to <b>February 4, 1987</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 4, 1987</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. |  |  |  |   |                                  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                  | 22c. DATE SIGNED<br><b>2-4-87</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Hany Elnamal M.D.</b>  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr, 21237</b>  |  |   |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>2/5/87</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SecurityProcess</b>  |                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ConnellyFuneralHome 300MaceAve. 21221</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 10 1987</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 4E shows any injury, or other traumatic event, the medical examiner must be notified at once.





BP

DHMH : 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director's carbon papers, pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Louise Parker Rutgers</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>12</b> YEAR <b>87</b>                     |   |  | 2b. HOUR<br><b>2:30 P.M.</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>4</b> YEAR <b>1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Indiana</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lutherville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2203 Dulaney Valley Rd. 21093</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                            |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>68 Acorn Circle 21204</b>              |  |
| 14. FATHER'S NAME<br>FIRST <b>Alfred</b> MIDDLE <b>E.</b> LAST <b>Parker</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b></b> LAST <b>Fauce</b>       |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>057-18-2184</b>  |  | 17. INFORMANT<br>ADDRESS <b>Rd. 21093</b><br><b>Mrs. Patricia Doeller 2203 Dulaney Valley</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPUL. Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Systemic Large cell lymphoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MIN</b><br><b>MONTHS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 70a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 71a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 71b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 71c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |   |  |
| 71d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 71e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 71f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 72a. I certify that (I) (this hospital) attended the deceased from <b>July 2, 1975</b> to <b>Feb 12, 1987</b> , that (I) (we) lost<br>saw the deceased alive on <b>JULY 30, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (we did not) view the body after death.   |  |   |  |   |  |   |  |   |  |
| 77b. SIGNATURE<br><b>S.J. Venable, Jr. M.D.</b>   |  |   |  |   | DEGREE<br><b>M.D.</b>  |   |  | 77c. DATE SIGNED<br><b>2-13-87</b>  |  |
| 77d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S.J. Venable, Jr. M.D.</b>  |  |   |  |   | 77e. ADDRESS<br><b>7215 York Rd.</b>   |   |  |   |  |
| 73a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 73b. DATE<br><b>2/16/87</b>   |  | 73c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  | 73d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Balto. Md.</b>                          |  |   |  |
| 74. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. 1050 York Rd.</b>   |  |   |  |   | 75a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1987</b>                                  |   | 75b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>  |   |  |



045914

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

03889

|  |             |   |  |  |  |   |  |   |  |   |  |  |  |
|--|-------------|---|--|--|--|---|--|---|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |             | FIRST<br>ADAM   |  | MIDDLE<br>F.   |  | LAST<br>SACK  |  | 2a. DATE KNOWN OF DEATH   |  | ESTIMATED<br>February 27, 1987                                  |  | 2b. HOUR<br>3:47 PM  |  |
| 3 SEX<br>M   | 4 RACE<br>W | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12/24/1908  |  | 6 AGE (IN YEARS<br>LAST BIRTHDAY)<br>78 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br>February 27, 1987                   |  | 7d. HOUR<br>3:47 PM  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |             | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD                |  |   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ENGINEER |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |  |  |
| 13a. STATE<br>MD   |             |   |  | 13b. COUNTY<br>BALTO.  |  | 13c. CITY OR TOWN<br>BALTO.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>3014 OAK FOREST DR 21234                 |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES C.G. SACK   |             |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY KOHLER  |  |   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES WWII  |             |   |  | 16b. SOCIAL SECURITY NO.<br>213-07-6321  |  | 17 INFORMANT ADDRESS<br>EMMA R. SACK 3014 OAK FOREST DR.                  |  |   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>   |             |   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>57 yrs</u>     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |             |   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |             |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  | 20 AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |             |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |             |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |             |   |  |  |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> Deputy MEDICAL EXAMINER   |             |   |  |  |  |   |  |   |  |   |  | DATE SIGNED <u>2/27/87</u>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <u>CHARLES F. O'DONNELL</u> ADDRESS <u></u>  |             |   |  |  |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |             |   |  | 23b. DATE<br>MAR. 2, 1987  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CRM                        |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. BALTO. MD. |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>HARTLEY MILLER 7527 HARFORD RD.   |             |   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 02 1987  |  | 25b. REGISTRAR'S SIGNATURE<br>A. J. Miller                      |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

1092

ONE

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211



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                          |  |  |  |   |  |   |                                  |
|--|--|---|--------------------------|--|--|--|---|--|---|----------------------------------|
| <div style="text-align: right;">87 03890<br/>REG. NO.</div>  |  |   |                          |  |  |  |   |  |   |                                  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John Francis Sanborn  |  |   |                          |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2-11-87                   |  |   |  |   | 2b. HOUR<br>4:55 AM              |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 27 06  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   | 7. IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>California  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                          |   |  |   |                                  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St Joseph Hosp |                          |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Athletic Trainer |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |                                  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore |  | 13c. CITY OR TOWN<br>Towson                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>8102 LaSalle Road 21204 |                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Sanborn   |  |   |                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Burke |  |   |  |   |                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>548-03-0836  |                          | 17. INFORMANT ADDRESS<br>Mr. Frank Clary 8102 LaSalle Road 21204   |  |  |   |  |   |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Massive Stroke with cerebral hemorrhage.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |                          |  |  |  |   |  |   |                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |                          |  |  |  |   |  |   |                                  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                          |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |   |                                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |   |                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> , 19 <u>87</u> , to <u>2/11</u> , 19 <u>87</u> , that (I) (we) lost<br>saw the deceased alive on <u>2/11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.       |  |   |                          |  |  |  |   |  |   |                                  |
| 22b. SIGNATURE<br><u>Adel S. El Hennawy</u>  |  |   |                          | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                |  |  |   | 22c. DATE SIGNED<br>2-11-87  |   |                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Adel S. El Hennawy  |  |   |                          | 22e. ADDRESS<br>SJH  |  |  |   |  |   |                                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>2/14/87  |                          | 23c. NAME OF CEMETERY OR CREMATORY<br>Christian Bro. Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Beltsville Maryland                    |   |  |   |                                  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. 5305 Harford Road 21214  |  |   |                          | 25a. DATE RECEIVED BY REGISTRAR<br>FEB 13 1987   |  | 25b. REGISTRAR'S SIGNATURE   |   |  |   |                                  |



TO FURNISH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the remaining pages to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18 shows any injury, other traumatic event, the medical examiner must be notified by phone.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | REG. NO. 87 03891   |  |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br><b>MARY</b>   | MIDDLE<br><b>E.</b>   | LAST<br><b>SANTIAGO</b>  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 20 '87</b>   |  |  | 2b. HOUR<br><b>8:10P</b><br>M  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 9, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b><br>YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b><br>MD.   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS)<br><b>GMC-6701 N. CHARLES ST.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |   |  |
| 13a. STATE<br><b>Md.</b>   |  |  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Towson</b>                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John E. Fantom</b>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie L. Taylor</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220 14 2043</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. David C. Deaver 5917 Burgess Ave. -14</b>  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b>  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>PULMONARY EDEMA</b>   |  |  |  |   |  |  |  |  |  |   |  |
| (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>  |  |  |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><b>RENAL FAILURE</b>  |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2) |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/15</b> 19 <b>87</b> , to <b>2/20</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2/20</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>V. Poonai</i>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>2/20/87</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>V. POONAI, M.D.</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>GMC-6701 N. CHARLES ST.</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>2/24/87</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>                    |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Timonium, Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD Home, Inc. 6500 York Rd.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 25 1987</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia S. ...</i>  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the burial-transit papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 87 03892   |  | 5:55 P.M.  |  | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| Simon  |  | Sapperstein  |  |  |  |  |  | 2-3-87  |  | 1755 P.M.                                    |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| MALE   |  | WHITE  |  | 10 24 96   |  | 90 YRS   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| POLAND   |  | USA  |  |  |  | BALTIMORE COUNTY MD  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  |   |  |  |  |
| RANDALLSTOWN   |  | BALTIMORE COUNTY GEN. HOSP.  |  |  |  |  |  |   |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |   |  |  |  |
| (CANDLER) INSPECTOR  |  | (EGGS) FOOD  |  |  |  |  |  |   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE  |  |  |  |
| MARYLAND   |  | Balt   |  | BALTO.   |  |  |  | 6801 WELLWOOD CT.   |  | 21209  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |  |  |
| SRUEL  |  |  |  | SAPPERSTEIN  |  |  |  | UNKNOWN   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |  |  |   |  |  |  |
| NO   |  | 212-01-6024  |  | BENJAMIN SAPPERSTEIN   |  | 6801 WELLWOOD CT.  |  | BALTO., MD  |  | 21209  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) CA of Colon and prostate<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c) |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Congestive Heart Failure - metastatic disease - Dehydration  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-2, 19 87, to 2-3, 19 87 that (I) (we) last saw the deceased alive on 2-3-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  |  |  | 22c. DATE SIGNED   |  |   |  |  |  |
| Raefat Girgis  |  |  |  |  |  | 2-3-87   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |   |  |  |  |
| Raefat Girgis  |  | Baltimore County Hospital  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| BURIAL   |  | FEB. 5, 1987   |  | SHAAREI ZION   |  | ROSEDALE BALTO. MD   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  |  |  | FEB 10 1987  |  |   |  |  |  |

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FOR  
STATE  
REGISTRAR

TENA

ELIZABETH

SARVER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87

REG. NO.

03893

|  |  |  |   |   |  |  |   |   |   |  |
|--|--|--|---|---|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Tena Elizabeth Sarver</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>Feb 01 87</b>                          |   |  | 2b. HOUR<br><b>1130 PM</b>   |   |   |   |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>03 06 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Rickness Hall, Inc</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>R.N.</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Nursing</b>   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b>   |  |  | 13b. COUNTY<br><b>Ba.</b>   |   | 13c. CITY OR TOWN<br><b>Towson</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>701 Thornwood Ct 21204</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James W McCurdy</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Tena E. Torner</b>        |   |  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>233 46-2313</b> |   |  | 16c. INFORMATION ADDRESS<br><b>Rickness Hall, Inc</b>  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>COPD.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b><br>10 years<br>20 " |  |  |   |   |  |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>   |  |  |   |   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>1-29-87</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>               |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-29-87</b> to <b>2-1-87</b> , that (I) <del>have</del> lost<br>saw the deceased alive on <b>1-29-87</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                      |  |  |   |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>K.A. Manley</b>   |  |  | DEGREE<br><b>MD</b>   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>2-2-87</b>                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K.A. MANLEY MD</b>   |  |  | 22e. ADDRESS<br><b>616 Chestnut Ave Towson, Md 21204</b>                      |   |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |  | 23b. DATE<br><b>Feb. 4, 1987</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crestview Cemetery</b>                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Grove City, Pennsylvania</b>                   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |  |  | ADDRESS<br><b>1050 York Road Towson, Md. 21204</b>                            |   | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 4 1987</b>                              |  | 25b. REGISTRAR'S SIGNATURE  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon plates and return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will require the medical examiner's certificate.

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044266 FEB

DIVISION OF VITAL RECORDS, 200 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-EM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 200 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 03894

|  |  |  |  |   |  |   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
|--|--|--|--|---|--|---|--|--|--|---------------------------------------|--|-------------------------|--|----------|--|---------|--|----------|--|
| 1. FOR STATE REGISTRAR   |  | 2. DECEASED NAME (TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST   |  | 3. DATE KNOWN OF DEATH                |  | 4. MONTH                |  | 5. DAY   |  | 6. YEAR |  | 7. HOUR  |  |
|  |  | Phillip David Scannell   |  |   |  |   |  |  |  | 2                                     |  | 12                      |  | 1987     |  |         |  | M        |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                                   |  | IF UNDER 24 HRS.                      |  | 7. DATE PRONOUNCED DEAD |  | 8. MONTH |  | 9. DAY  |  | 10. YEAR |  |
| Male   |  | White  |  | Nov. 16, 1986   |  | YRS. 2  |  | DAYS 27  |  | HOURS                                 |  | 2                       |  | 12       |  | 1987    |  | 8:15A M  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 8. CITIZEN OF WHAT COUNTRY?  |  | 9. MARRIED  |  | 10. NEVER MARRIED   |  | 11. DIVORCED                                     |  | 12. BALTIMORE CITY OR COUNTY OF DEATH |  |                         |  |          |  |         |  |          |  |
| Maryland   |  | U.S.A.   |  | <input type="checkbox"/>  |  | <input checked="" type="checkbox"/>                                 |  | <input type="checkbox"/>                         |  | Baltimore County,                     |  |                         |  |          |  |         |  | MD       |  |
| 13. CITY OR TOWN OF DEATH  |  | 14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                  |  | 16. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
| Catonsville  |  | 116 1/2 Smithwood Avenue   |  | N/A   |  | N/A   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
| 17. STATE  |  | 18. COUNTY   |  | 19. CITY OR TOWN  |  | 20. INSIDE CITY LIMITS?   |  | 21. STREET ADDRESS                               |  |                                       |  |                         |  |          |  |         |  |          |  |
| Maryland   |  | Baltimore  |  | Catonsville   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 116 1/2 Smithwood Avenue                         |  |                                       |  |                         |  |          |  |         |  |          |  |
| 22. FATHER'S NAME  |  | 23. MOTHER'S MAIDEN NAME   |  | 24. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  | 25. SOCIAL SECURITY NO.   |  | 26. INFORMANT                                    |  | 27. ADDRESS                           |  |                         |  |          |  |         |  |          |  |
| David Wayne Scannell   |  | Teresa Evans   |  | No  |  | N/A   |  | David W. Scannell                                |  | Same as # 13                          |  |                         |  |          |  |         |  |          |  |
| 28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 29. PART I DEATH WAS CAUSED BY:  |  | 30. IMMEDIATE CAUSE (a)   |  | 31. DUE TO, OR AS A CONSEQUENCE OF                                  |  | 32. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                       |  |                         |  |          |  |         |  |          |  |
|  |  |  |  | Sudden Infant Death Syndrome  |  |   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
|  |  |  |  | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |  | (b)   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
|  |  |  |  |   |  | (c)   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
| 33. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |  |  |   |  |   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
| 34. DATE OF OPERATION  |  | 35. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 36. AUTOPSY?  |  |   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  |   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
| 37. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 38. TIME OF INJURY   |  | 39. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                  |  |   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
|  |  | P.M. 19  |  |   |  |   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
| 40. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  | 41. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 42. LOCATION  |  |   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
|  |  |  |  | STREET  |  | CITY OR TOWN  |  | COUNTY   |  | STATE                                 |  |                         |  |          |  |         |  |          |  |
| 43. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: |  | 44. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
| 45. ACTUAL SIGNATURE   |  | 46. TITLE (SPECIFY)  |  | 47. MEDICAL EXAMINER  |  | 48. DATE SIGNED   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
| William M. Zane  |  | Assistant  |  |   |  | 2/13/87   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
| 49. EXAMINER'S NAME (TYPE OR PRINT)  |  | 50. ADDRESS  |  |   |  |   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
| William M. Zane, M.D.  |  | 111 Penn St. Balto., MD.   |  |   |  |   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
| 51. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 52. DATE   |  | 53. NAME OF CEMETERY OR CREMATORY   |  | 54. LOCATION  |  | 55. COUNTY                                       |  | 56. STATE                             |  |                         |  |          |  |         |  |          |  |
| Burial   |  | 2/17/87  |  | Meadowridge   |  | Dorsey  |  | Maryland   |  |                                       |  |                         |  |          |  |         |  |          |  |
| 57. FUNERAL DIRECTOR   |  | 58. DATE REC'D. BY REGISTRAR   |  | 59. REGISTRAR'S SIGNATURE   |  |   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
| Leroy M. & Russell C. Witzke Funeral Homes P.A.  |  | FEB 17 1987  |  | Julia Davidson-Randall  |  |   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |
| 1630 Edmondson Avenue, Catonsville, MD. 21228  |  |  |  |   |  |   |  |  |  |                                       |  |                         |  |          |  |         |  |          |  |

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044286 FEB 17 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 03895  
REG. NO.

|   |  |   |   |   |                                       |  |  |   |  |  |
|---|--|---|---|---|---------------------------------------|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Antionette Schiavo</b>                  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 5 87</b>                |   |                                       | 2b. HOUR<br><b>2:17 AM</b>   |  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>white</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 02 83</b>   |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |  |
| 13a. STATE<br><b>MD.</b>  |  |   | 13b. COUNTY<br><b>BALTO.</b>  |   | 13c. CITY OR TOWN<br><b>BALTO.</b>    |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>3315 LAWNVIEW AVE 21213</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick Pessano</b>                |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY FERMES</b> |   |                                       |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  |   | 16b. SOCIAL SECURITY NO.<br><b>213-01-2565D</b>                     |   | 17. INFORMANT<br><b>FRANK SCHIAVO</b> |  | ADDRESS<br><b>3315 LAWNVIEW AVE 21213</b>  |   |  |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute and Chronic Respiratory Failure</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 days</b>   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Pulmonary Disease</b> many years               |  |
|   |  | DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular Dis.; Congestive Heart Failure</b> |  |

|  |  |  |  |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Polycystic Kidney Disease; multiple Abdominal Neoplasms</b> |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                 |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |

|  |  |  |  |
|--|--|--|--|
| 21a. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>—</b>                        |  | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21c. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b> |  | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>—</b>                  |  |

|   |  |
|---|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 87</b> to <b>Feb 5 19 87</b> , that (I) (we) last saw the deceased alive on <b>2-4-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |
|---|--|

|   |  |                     |  |  |  |                                   |  |
|---|--|---------------------|--|--|--|-----------------------------------|--|
| 22b. SIGNATURE<br><b>Wm Carl Ebeling MD</b>                   |  | DEGREE<br><b>MD</b> |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2-5-87</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. C. EBELING</b> |  |                     |  | 22e. ADDRESS<br><b>7401 Osler St Balto Md 21204</b>  |  |                                   |  |

|  |  |                            |  |  |  |   |  |
|--|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>       |  | 23b. DATE<br><b>2-7-87</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO BALTO MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Frank Deeb Boet</b> |  |                            |  | 25. ADDRESS<br><b>322 S. High St</b>                       |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, translation, or removal.

IMPORTANT: If item 21 is marked on Item 18, show city, injury, or other traumatic event, the medical certificate must be marked as such.

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

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100 10 000



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |                                      |   |
|---|--|---|--|--------------------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARVIN Douglas Schisler</b>                |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>2 1 87</b> 2b. HOUR <b>7:38 PM</b>                                 |                                      |   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-23-1937</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS   |                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                                    |                                      |   |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>STELLA Maris Hospice</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>                   |                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Superintendent</b>                                      |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Woodlawn</b> | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Roland Schisler</b>                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Hale</b>                                      |                                      |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-34-2422</b>   | 17. INFORMANT <b>Owings Mills</b> ADDRESS <b>MD 21117</b><br><b>Mr. Douglas Schisler 3K Troled Ct.</b> |                                      |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**RENAL Carcinoma with Bone Met-ASTASES**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/20/87</b> , 19 <b>87</b> , to <b>2/1/87</b> , 19 <b>87</b> that (I) (we) last saw the deceased alive on <b>2/1/87</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Carla S. Alexander</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/2/87</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carla S. Alexander, M.D.</b>  |  | 22e. ADDRESS<br><b>Stella Maris Dulaney Valley Rd. - Towson, MD 21204</b> |  |  |  |

|   |                            |  |  |
|---|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                  | 23b. DATE<br><b>2-4-87</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b> |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 03 1987</b>            | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Swenson-Randall</b>                 |
| 24. ADDRESS<br><b>8728 Liberty Rd. Randallstown, MD 21133</b>               |                            |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach this certificate to the other papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item (b), the medical examiner must be notified.

Handwritten text, mostly illegible due to fading and bleed-through. The text appears to be organized into sections or paragraphs, with some lines underlined. A circular stamp or mark is visible on the right side of the page.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 3 8 9 1

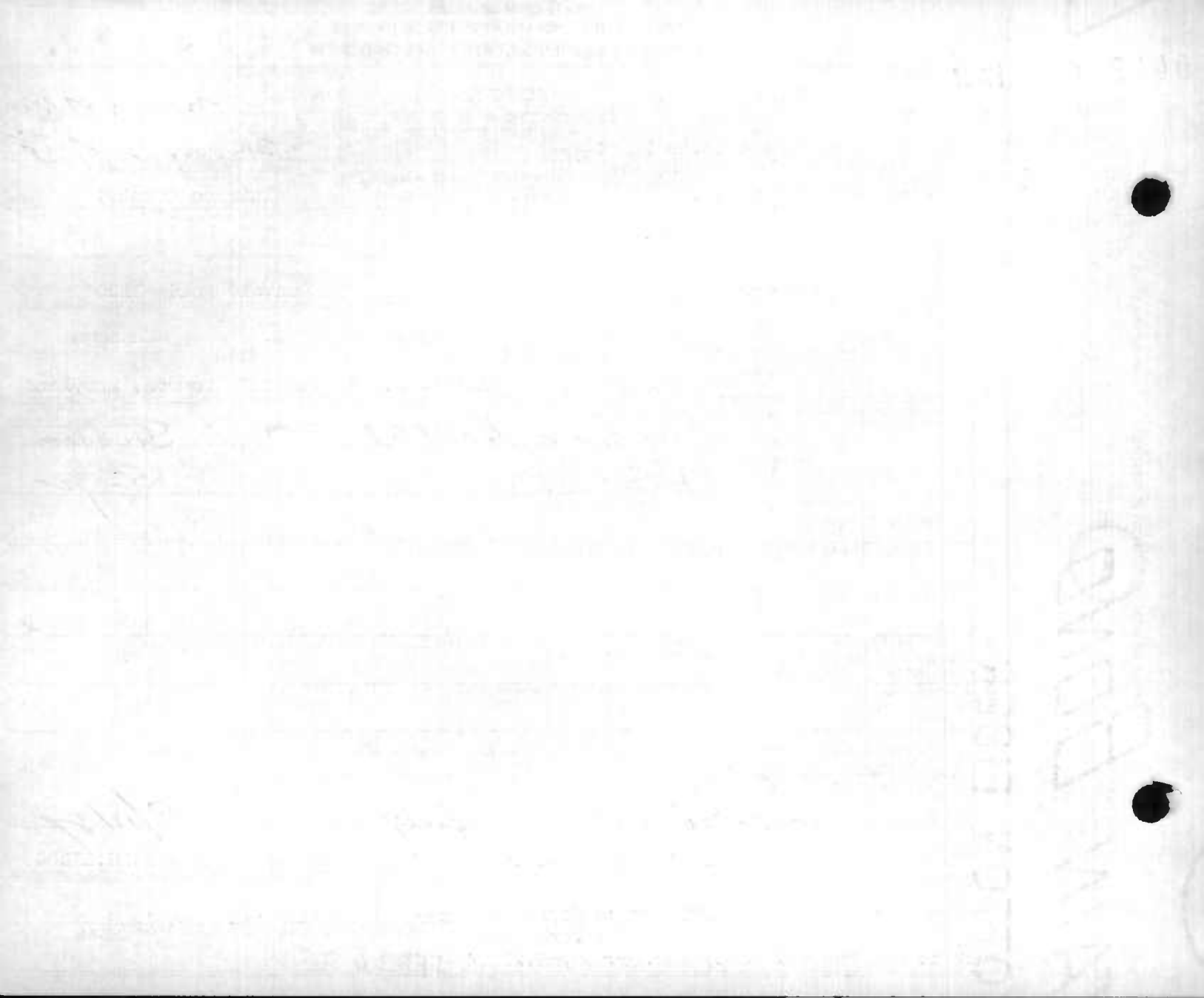
FOR  
1- STATE  
REGISTRAR

|  |         |  |  |   |  |   |  |                                     |  |                                |  |       |  |      |  |          |  |
|--|---------|--|--|---|--|---|--|-------------------------------------|--|--------------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF ESTI-<br>MATED |  | MONTH                          |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| FERDINAND  |         | H.   |  | SCHMIDT   |  |   |  | February 16 1987                    |  |                                |  |       |  |      |  | 11:00 AM |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                    |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| Male   | White   | Sept. 13, 1902   |  | 84 YRS.   |  |   |  |                                     |  | February 16 1987               |  |       |  |      |  | 1987     |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                     |  |                                |  |       |  |      |  | MD       |  |
| Unknown  |         | U.S.A.   |  |   |  | Baltimore County,   |  |                                     |  |                                |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |                                     |  |                                |  |       |  |      |  |          |  |
| Towson   |         | 16 Dunvale Road Room #20   |  | None  |  |   |  |                                     |  |                                |  |       |  |      |  |          |  |
| 13a. STATE   |         | 13b. CITY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                 |  |                                |  |       |  |      |  |          |  |
| Maryland   |         | Baltimore  |  | Towson  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 16 Dunvale Road 21204               |  |                                |  |       |  |      |  |          |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                                     |  |                                |  |       |  |      |  |          |  |
| Charles  |         | Matilda  |  | C.  |  | Unknown   |  |                                     |  |                                |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                                     |  |                                |  |       |  |      |  |          |  |
| No   |         | 216-52-9674  |  | William J. Wiseman, III   |  | Towson, Maryland  |  |                                     |  |                                |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line of (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last<br>(b) <u>ASCLD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>  |         | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>5+ yr</u>                           |  |   |  |   |  |                                     |  |                                |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |  |   |  |                                     |  |                                |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |   |  |                                     |  |                                |  |       |  |      |  |          |  |
|  |         |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |                                     |  |                                |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |                                     |  |                                |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                     |  |                                |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |         |  |  |   |  |   |  |                                     |  |                                |  |       |  |      |  |          |  |
| ACTUAL<br>SIGNATURE <u>Charles F. O'Donnell</u>  |         | TITLE (SPECIFY)<br><u>Medical Examiner</u>   |  | DATE<br>SIGNED <u>2/16/87</u>   |  |   |  |                                     |  |                                |  |       |  |      |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |  | 7501 York Road  |  | Towson, Md. 21204   |  |                                     |  |                                |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                                     |  |                                |  |       |  |      |  |          |  |
| Cremation  |         | Feb. 16, 1987  |  | Green Mount Crematory   |  | Baltimore, Maryland   |  |                                     |  |                                |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME   |         | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                     |  |                                |  |       |  |      |  |          |  |
| Ruck Towson Funeral Home, Inc.   |         | 1050 York Road<br>Towson, md. 21204  |  | FEB 13 1987   |  | <u>John Anderson-Randall</u>  |  |                                     |  |                                |  |       |  |      |  |          |  |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE COMPLETED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION



BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that all death certificates be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove all other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |                             |
|---|--|---|--|---|--|--|--|---|--|-----------------------------|
| 1- STATE REGISTRAR  |  |   |  |   |  |  |  |   |  |                             |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>KATHLEEN L. SCHMUFF</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR 2 26 87 |  |  |   |  | 2b. HOUR 7 <sup>05</sup> AM |
| 3 SEX Female  |  | 4 RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR 7 16 20   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. md   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.  |  |   |  |                             |
| 10. CITY OR TOWN OF DEATH Towson md   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER  |  | 12b. KIND OF BUSINESS OR INDUSTRY -   |  |                             |
| 13a. STATE md   |  | 13b. COUNTY ME  |  | 13c. CITY OR TOWN Balto. city   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE 3672 Cheslerfield Ave 21213  |  |                             |
| 14. FATHER'S NAME FIRST MIDDLE LAST EDMUND MCNEILL  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE WALTHER   |  |   |  |  |  |   |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  | 16b. SOCIAL SECURITY NO. 213-16-3467  |  | 17 INFORMANT ADDRESS CLAYTON SCHMUFF (HUSBAND) SAME ADDRESS   |  |  |  |   |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |   |  |                             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |  |   |  |   |  |  |  |   |  |                             |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |                             |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-21, 19 87, to 2-26, 19 87, that (I) (we) last saw the deceased alive on 2/26, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |                             |
| 22b. SIGNATURE  |  | DEGREE  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED 2-26-87  |  |                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eddie Nakhuda, M.D.   |  |   |  | 22e. ADDRESS Stella Maris 2300 Dulaney Valley Rd.-Towson, MD 21204  |  |  |  |   |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  | 23b. DATE 2/28/87   |  | 23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH   |  | 23d. LOCATION CITY OR TOWN BALTIMORE COUNTY STATE MD   |  | 23e. DATE FEB 27 1987   |  |                             |
| 24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213   |  |   |  |   |  |  |  |   |  |                             |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03899

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA</b> <b>Schneider</b>                  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2- 16- 87</b> |   |  | 2b. HOUR<br><b>5:12AM</b>                                       |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-26- 04</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto COUNTY</b> MD. |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>RIVERVIEW NURSING CENTRE</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>                  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>--</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Emmanuel Smith</b>                   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Ortell</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>--</b>   |  | 17. INFORMANT ADDRESS<br><b>21234 Robert C. Schneider, 2717 Placid Ave.,</b>  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Arteriosclerotic Coronary Vascular Disease**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**Coronary Arteriosclerotic Disease**

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Michael Schwartz MD</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/16/87</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Schwartz MD</b>  |  |  |  | 22e. ADDRESS   |  |   |  |

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                   |  | 23b. DATE<br><b>2/19/87</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SCHIMUNEK FUNERAL HOME, Balto, Md. 21213</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1987</b>           |  | 25b. REGISTRAR'S SIGNATURE<br><b>A. J. Anderson-Randall</b>         |  |

120% POLYMERIZATION

100% POLYMERIZATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  | REG. NO. 87 03900   |  |                           |  |
|---|--|---|--|--|--|--|--|--|--|---|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Francis A. Schwender</b>  |  |   |  |  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>2 15 87</b>   |  | 2b. HOUR <b>9:30 A.M.</b> |  |
| 3. SEX <b>M Male</b>  |  | 4. RACE <b>W White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>2 18 19</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>  |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 7. IF UNDER 24 HRS. HOURS MIN.  |  |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>                     |  |  |  |   |  |                           |  |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Senior Engineer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Western Elec.</b>                                       |  |   |  |                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>   |  |   |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Timonium</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Schwender</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Muller</b>   |  |  |  | 13e. STREET ADDRESS / ZIP CODE <b>237 Treherne Rd., 21093</b>                                |  |   |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  |   |  | 16b. SOCIAL SECURITY NO. <b>WW 11 111-07-6155</b>  |  | 17. INFORMANT ADDRESS <b>Eleanor H. Schwender, 237 Treherne Rd., 21093</b>           |  |  |  |   |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Parkinson's Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |  |  |  |  |  |   |  |                           |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR (A.M. P.M.) MONTH DAY YEAR <b>9:30 P.M. 2 15 87</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |   |  |                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |  |  |   |  |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |  |  |   |  |                           |  |
| 22b. SIGNATURE <b>Robert B. Geller MD</b>   |  |   |  |  |  | DEGREE   |  | 22c. DATE SIGNED <b>2/15/87</b>  |  |   |  |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT B. GELLER, MD</b>   |  |   |  |  |  | 22e. ADDRESS <b>ST. JOSEPH HOSPITAL</b>  |  |  |  |   |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |   |  | 23b. DATE <b>2/18/87</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Gardens</b>                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Timonium Balto. Md.</b>                           |  |   |  |                           |  |
| 24. FUNERAL DIRECTOR <b>Bryan W. Clary, 10 W. Padonia Rd., 21093</b>  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 18 1987</b>                                     |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>                                     |  |   |  |                           |  |

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1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is of great importance in the theory of differential equations. The second part of the paper is devoted to a detailed study of the problem. It is shown that the problem is of great importance in the theory of differential equations. The third part of the paper is devoted to a detailed study of the problem. It is shown that the problem is of great importance in the theory of differential equations.

2. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is of great importance in the theory of differential equations. The second part of the paper is devoted to a detailed study of the problem. It is shown that the problem is of great importance in the theory of differential equations. The third part of the paper is devoted to a detailed study of the problem. It is shown that the problem is of great importance in the theory of differential equations.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 03901  
REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Catherine Anna Seeley</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 5 1987</b>          |   |  | 2b. HOUR<br><b>118A</b> M   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 1 1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Secretary</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Lochearn</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3605 Landbeck Rd. 21207</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Chiada</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amelia Schwert</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-01-8087</b>  |  | 17. INFORMANT<br><b>Mr. Paul R. Seeley</b> ADDRESS<br><b>3605 Landbeck Rd. Baltimore Maryland 21207</b> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PULMONARY HYPERTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MITRAL STENOSIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-03</b> , 19 <b>87</b> , to <b>2-05</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2-05</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>R. DEPESTINE</b>  |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>2-5-87</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. DEPESTINE</b>   |  |   |  | 22e. ADDRESS<br><b>Baltimore County General Hospital</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>2-7-87</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>                 |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore MD</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>  |  |   |  |   | 25. REGISTRAR'S SIGNATURE<br><b>Julia Sinden-Rudman</b>                        |   |  |  |  |
| 8728 Liberty Rd. Randallstown, MD 21133  |  |   |  |   | FEB 6 1987   |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove containing pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

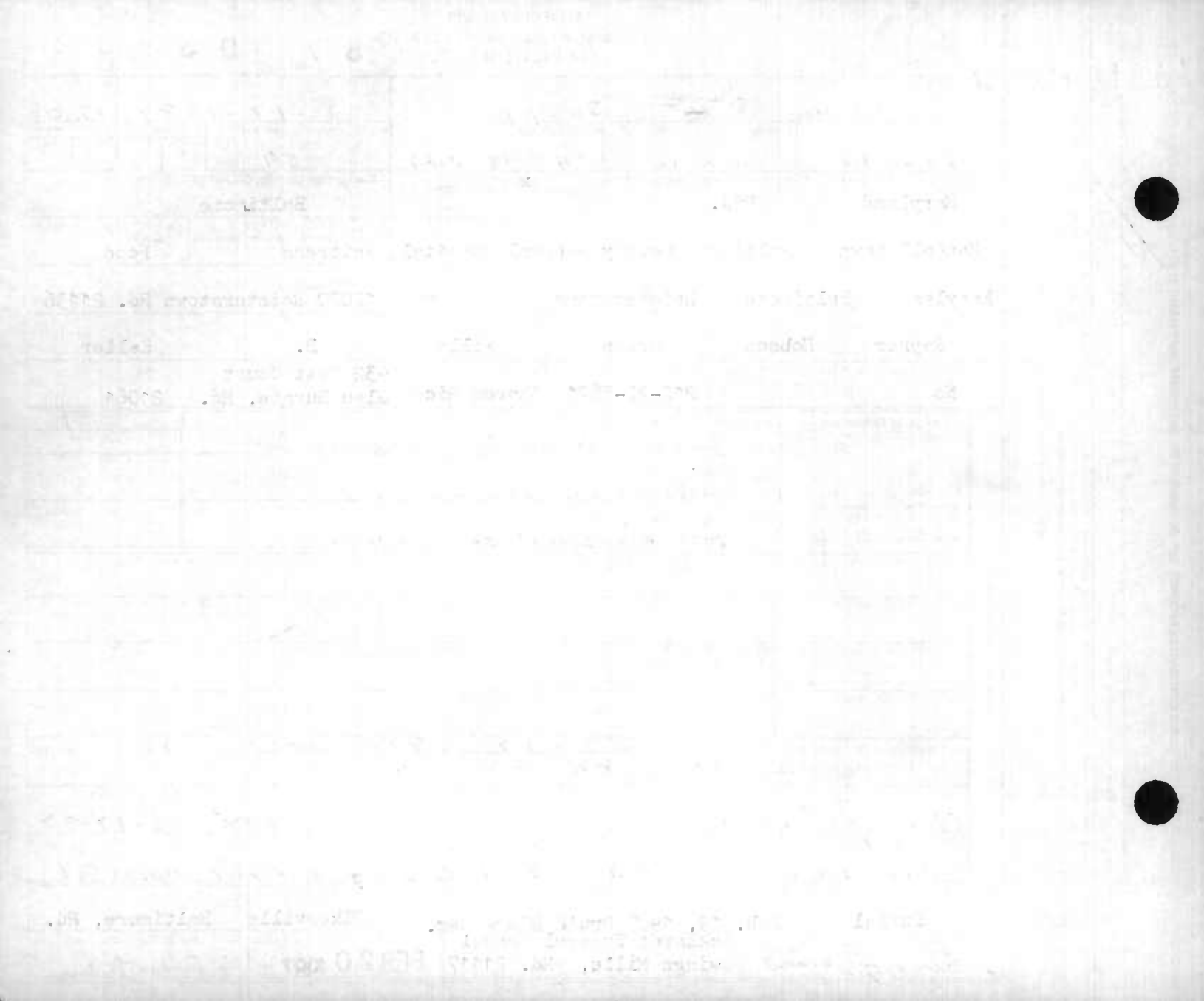
IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

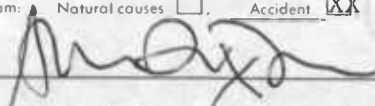
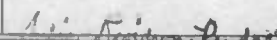
REG. NO. 87 03902

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Willa Lee Seipp  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2-17-1987  |  | 2b. HOUR<br>1530 M  |  |
| 3. SEX<br>Female  | 4. RACE<br>white   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 18 1927   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Waitress   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Food  |
| 13a. STATE<br>Maryland  |  | 13b. CITY<br>Baltimore  | 13c. CITY OR TOWN<br>Reisterstown  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Rayner Hobson Green   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Willa B. Keller  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-22-3621   | 17. INFORMANT<br>432 West Court<br>Sharon Rice Glen Burnie, Md. 21061   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Aspiration Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Possible bowel obstruction</u> |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-17</u> , 19 <u>87</u> , to <u>2-17</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2-17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Allen J. Chubbuck M.D.</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>2-17-87</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Allen J. Chubbuck M.D.</u>  |  | 22e. ADDRESS<br><u>Balt. County General Hospital</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   | 23b. DATE<br>Feb. 19, 1987   | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cem.  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville Baltimore, Md.        |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>P. Larry Hoffmeyer</u>   |  | Eckhardt Funeral Chapel<br>Owings Mills, Md. 21117  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 20 1987  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>  |

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| FOR F.H. / Gbj. DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |              |  |   |  |  |  |  |  | REG. NO. 03903   |  |
|--|--|--------------|--|---|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR   |  |              |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2-27 1987 |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph J. Serio                                    |  |              |  |   |  |  |  |  |  | 2b. HOUR OF ESTI- MATED DEATH <input type="checkbox"/> 2-27 1987 M                         |  |
| 3 SEX Male   |  | 4 RACE White |  | 5 DATE OF BIRTH MONTH DAY YEAR 12 27 1917   |  | 6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS. |  | 7c. DATE PRONOUNCED DEAD 2-27 1987   |  | 2d. HOUR 11:50 P. M  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  |              |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.                                 |  |
| 10 CITY OR TOWN OF DEATH Woodlawn  |  |              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5910 Montgomery Street                              |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book Dealer  |  | 12b. KIND OF BUSINESS OR INDUSTRY Books  |  |
| 13a. STATE Maryland  |  |              |  | 13b. COUNTY Baltimore   |  | 13c. CITY OR TOWN Woodlawn             |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS Md. 21207 5910 Montgomery St. Woodlawn                                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Serio  |  |              |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosaria Forte  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes WW II   |  |  |  |
| 16b. SOCIAL SECURITY NO. 213-16-3151   |  |              |  | 17. INFORMANT Cecil Serio 937 Grove Hill Arbutus, Md.   |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke Inhalation and Thermal Injury   |  |  |  |
| 8903   |  |              |  | (b) DUE TO, OR AS A CONSEQUENCE OF  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF   |  |              |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10. Congestive Heart Failure |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 19a. DATE OF OPERATION   |  |              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  |
| 21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 9:36 P.M. 2-27 1987      |  |              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject recovered from house fire   |  |  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home                                     |  |              |  | 21f. LOCATION CITY OR TOWN COUNTY STATE 5910 Montgomery St., Balto. Co., Maryland   |  |  |  | 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |
| ACTUAL SIGNATURE  |  |              |  | TITLE (SPECIFY) M.D. Deputy Chief   |  |  |  | DATE SIGNED 2-28-87  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.   |  |              |  | ADDRESS 111 Penn St., Balto., Md. 21201   |  |  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation  |  |  |  |
| 23b. DATE 3/2/87   |  |              |  | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Md.  |  |  |  |
| 24 FUNERAL DIRECTOR NAME Leroy M. & Russell C. Witzke Funeral Home                                   |  |              |  | 25a. DATE REC'D. BY REGISTRAR 05 1987   |  |  |  | 25b. REGISTRAR'S SIGNATURE    |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITHIN 72 HOURS, THE MEDICAL EXAMINER SHALL SIGN AND DATE THE CERTIFICATE. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 3 9 0 4  
REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES SIDNEY SHAFFER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 7 1987</b>                                   |  | 2b. HOUR<br><b>1:45 PM</b>  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 8, 1919</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Med Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Property Admin.</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Federal Gov't.</b>  |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>119 Register Ave. 21212</b>                     |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Sidney Shaffer, Sr.</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carolyn Mullens</b>                         |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>yes WW II</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-12-1662</b>  | 17. INFORMANT ADDRESS<br><b>Doris L. Shaffer Same</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Sepsis</b>  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Intraabdominal Sepsis</b>  |  |   |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Perforated duodenal ulcer</b>  |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Amyotrophic Lateral Sclerosis</b>  |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 15</b> , 19 <b>87</b> , to <b>Feb. 7</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>Feb. 7</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><i>John E. Adams</i> M.D.   |  |   |   | 22c. DATE SIGNED<br><b>Feb. 8, 1987</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John E. Adams, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>6701 N. Charles Street, Towson, Md.</b>                           |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/11/87</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville, Baltimore Co., Md.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto., Md. 21212</b>  |  |   | 25a. DATE RECEIVED BY REGISTRAR<br><b>FEB 11 1987</b>   |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

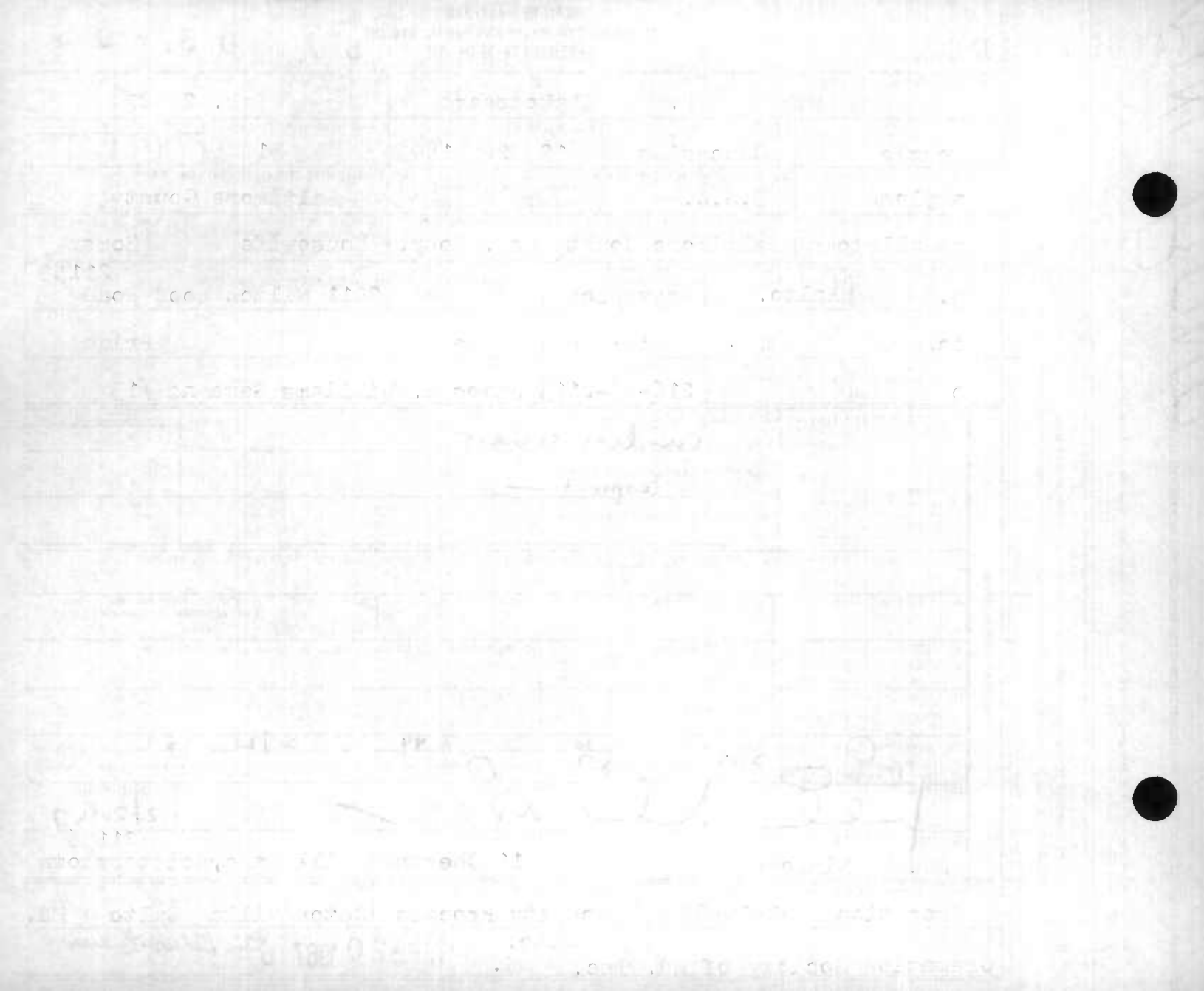
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Part 2 is marked on Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 87 03905  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ruth B. Shakespeare</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 20 87</b>   |  |   |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>Caucasian</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>12 20 1895</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS. MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County Gen. Hosp.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13a. STREET ADDRESS / ZIP CODE <b>21153</b>  |  |   |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>Balto.</b>   |  | 13c. CITY OR TOWN <b>Stevenson</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard Henry Williams</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Brian</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>216-46-0113</b>   |  | 17. INFORMANT ADDRESS <b>James E. Williams Same as #13</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>aspiration</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>10</b> 19 <b>84</b> to <b>2</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2/19</b> 19 <b>87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Judah Minkove</b>  |  | DEGREE <b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>2/20/87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Judah Minkove</b>   |  | 22e. ADDRESS <b>11 Chestnut Hill Lane, Reisterstown</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  | 23b. DATE <b>2-20-87</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Security Process</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Cremation Society of Md. Inc.</b>   |  | ADDRESS <b>Balto. Md.</b>   |  | 25a. DATE REC'D BY REGISTRAR (S) REGISTRAR'S SIGNATURE <b>FEB 20 1987 Julia Dando-Randall</b>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

| FOR Item # 5, Film G 625, 3/3/87   |  |  |  |  |   |  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |  |  | 87 03906<br>REG. NO.  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Helen Audrey Shirey</b>   |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>Feb. 21, 1987</b>   |  |  |  |  |   |  |  |  |  | 2b. HOUR<br><b>7:30 PM</b>  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>Female</b>  |  |  |  |  | 4. RACE<br><b>White</b>   |  |  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>March 28, 1904</b>   |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.   |  |  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                          |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD.  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hosp</b> |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home maker</b>   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                  |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  |  | 13b. COUNTY<br><b>Harford</b>   |  |  |  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |  |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>820 South Caton Avenue 21229</b> |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick Brunshear</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Ogle</b>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218.03.5376D</b>  |  |  |  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Frederick Shirey (son) Glen Burnie Maryland</b>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7:35 PM</b>  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><b>Dehydration, Renal Failure</b>  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>Feb 21 1987</b>   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Heart Bypass</b>   |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>7220 Park Heights Ave Baltimore MD</b>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Tasneem Lakhani</b>   |  |  |  |  |   |  |  |  |  | DEGREE<br><b>MD</b>  |  |  |  |  | 22c. DATE SIGNED<br><b>2/21/87</b>  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TASNEEM LAKHANI</b>  |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br><b>7220 Park Heights Ave Baltimore MD</b>  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  |  |  | 23b. DATE<br><b>Feb. 25, 1987</b>   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>The Greenwood Cemetery</b>  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lancaster, Lancaster, PA</b>   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Singleton Funeral Home</b>  |  |  |  |  |   |  |  |  |  | ADDRESS<br><b>Singleton Funeral Home, Glen Burnie, Md.</b>   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 23 1987</b>   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>           |  |  |  |  |  |  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 7 0 3 9 0 7  
REG. NO.1. FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |   |  |   |
|--|--|--|--|--|--|---|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>SOPHIE (nmi) SIBISTOWICZ</b>   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-17-87</b>   |  |  | 2b HOUR<br><b>2:35pm</b>  |  |   |
| 3 SEX<br><b>FEMALE</b>   |  |  | 4 RACE<br><b>WHITE</b>   |  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9- 9- 99</b>  |  |   |
| 6a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |  | 6b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><b>87 YRS.</b>  |  |   |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |   |
| 9 CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>RIVERVIEW NURSING CENTRE</b> |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  |   |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>RIVERVIEW NURSING CENTRE</b> |  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>- - - - -</b>  |  |   |
| 13a STATE<br><b>Maryland</b>   |  |  | 13b COUNTY<br><b>Baltimore</b>   |  |  | 13c CITY OR TOWN<br><b>Dundalk</b>  |  |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis Sarnecki</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pauline Dranka</b>  |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   |
| 16b SOCIAL SECURITY NO.<br><b>214-54-4843</b>  |  |  | 17 INFORMANT<br>ADDRESS<br><b>Stella E. Lockwood - 1903 Church Road 21222</b>  |  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>   |  |  |  |  |  |   |  |   |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11 Aug 1986</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |
| 21d INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |
| 22a I certify that (I) <b>the hospital</b> attended the deceased from <b>11 Aug 1986</b> to <b>17 Feb 1987</b> that (I) (we) last saw the deceased alive on <b>15 Feb 1987</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <b>we</b> (did) <b>(did not)</b> view the body after death. |  |  |  |  |  |   |  |   |
| 22b SIGNATURE<br><b>M. Rainess, M.D.</b>   |  |  |  |  |  | 22c. DATE SIGNED<br><b>2/18/87</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MORRIS RAINESS, MD</b>  |
| 22e ADDRESS<br><b>1105 OLD EASTERN AVE. 21221</b>  |  |  |  |  |  | 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   |
| 23b DATE<br><b>2/21/87</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Rosary Cemetery</b>  |  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Maryland</b>  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>George A. Ulbrich &amp; Sons Inc. - 705 S. Ave St.</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 20 1987</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John S. ...</b>  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the funeral director. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other significant event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |
| 1. FOR STATE REGISTRAR<br><b>John William Siegle</b>  |  | 20. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 01 87</b>   |  | 2b. HOUR<br><b>2:48 PM</b>  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN W. SIEGLE</b>  |  | 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 10 06</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> County MD   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Architect</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-employed</b>  |  |   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Cockeysville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 14. STREET ADDRESS / ZIP CODE<br><b>13029 Malcolm Cir Apt H 21030</b>           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Siegle</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Iva Siegle</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>N/A</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-07-0415</b>   |  | 17. INFORMANT<br><b>3728 Oak Ave 21207 Elizabeth Butcher</b>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Static lung carcinoma</b> |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>months</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>11 10 87</b> to <b>12 01 87</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) (if) did not see the body after death.   |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Dr. H. Copeland</b>  |  | 22c. DEGREE<br><b>MD</b>   |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |  | 22e. DATE SIGNED<br><b>2 2 87</b>  |  |   |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. H. Copeland</b>   |  | 22g. ADDRESS<br><b>MD 8620 Liberty Plaz 9 Mall</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Cremation</b>   |  | 23b. DATE<br><b>02-02-87</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Balto., MD</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Baltimore, MD 21228</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 3 1987</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John W. Siegle</b>   |  |  |  |   |  |
| 26. CREMATION SOCIETY OF MD   |  |  |  |   |  |  |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Lillian G. Simon   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEB 3 1987   |  | 2b. HOUR<br>3 P.M.   |
| 3. SEX<br>FEMALE  | 4. RACE<br>W   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC 26 1910  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO COUNTY MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1540 BARRETT RD |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MD  | 13b. COUNTY<br>BALTO   | 13c. CITY OR TOWN<br>REISTERSTOWN  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>509 ALTER AVE 21236                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>STACHAROWSKI  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>216-72-7664  |   | 17. INFORMANT<br>ADDRESS<br>MORRIS SIMON 509 ALTER AVE                         |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic lung Cancer<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 1986 to Feb 3, 1987, that (I) (we) lost saw the deceased alive on Oct 22, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |
| 22b. SIGNATURE<br>Charles Padgett MD  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |   | 22c. DATE SIGNED<br>2-4-87   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles Padgett  |  | 22e. ADDRESS<br>5601 Loch Raven Blvd. Balto MD 21239   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   | 23b. DATE<br>2/7/87  | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. STANISLAUS   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>DUNDALK MD                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>JOHN M WEBER & SONS INC   |  | ADDRESS<br>401 S CHESTER ST  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 5 1987                                    |  |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br>J. Deaton  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove critical papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked at item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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|  |  |  |   |   |                                      |  |  |
|--|--|--|---|---|--------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRANCIS X. SINNOTT</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 24, 1987</b> |   | 2b. HOUR<br><b>1:15P<sub>M</sub></b> |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 21, 1913</b>   |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>21234</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8515 CHESTNUT OAK ROAD</b>   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FIREFIGHTER</b>  |                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LOCAL GOV'T.</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>21234</b>   |                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES E. SINNOTT</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY T. TOULAN</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |                                      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-09-4896</b>  |  |
| 17. INFORMANT<br>ADDRESS<br><b>DOROTHY B. SINNOTT BALTIMORE, MD</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardio resp. Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>dehydration + malnutrition</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>locally advanced cancer of the tongue</b> |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>months</b><br><b>months</b>  |                                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |  |   |   |                                      |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/30, 1986</b> to <b>2/24, 1987</b> , that (I) (we) lost saw the deceased alive on <b>11/14, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |                                      |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALBERT L. BLUMBERG, M.D.</b>   |  | 22c. ADDRESS<br><b>GBMC 828-2540</b>   |   | 22d. DATE SIGNED<br><b>2/25/87</b>  |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>FEB. 27, '87</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEMETERY</b>  |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CO., MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM E. JOHNSON</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 25 1987</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Parker-Randall</i>   |                                      |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please inform the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

BP

12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

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*[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper tags. Tag 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 87 03941   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JOHN HENRY SKEEN JR.  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 24, 1987   |  |   |  | 2b. HOUR<br>5:30P M  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>December 5, 1915   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>806 Hatherleigh Road 21212 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Lawyer    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Law   |  |
| 13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Henry Skeen Sr.   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Alice Mathilda Armiger  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII   |  | 17. INFORMANT ADDRESS<br>D.H.Skeen 806 Hatherleigh Road 21212   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Severe chronic obstructive pulmonary disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Congestive Heart Failure</u>  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24 hours<br>10 years<br>3 days   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><u>Diabetes Mellitus</u>  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) <del>XXXXXX</del> attended the deceased from <u>9-20-63</u> , 19____, to <u>Present</u> , 19____, that (I) <del>(we)</del> lost<br>saw the deceased alive on <u>2-24-87</u> , 19____, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>(we)</del> (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Wilfred H. Townsend</u>  |  |   |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  | 22c. DATE SIGNED<br>2-26-87  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Wilfred H. Townsend  |  |   |  | 22e. ADDRESS<br><del>XXXXXXXXXXXX</del> 14 E. Eager St.   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>2-27-87  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lutherville Baltimore, Maryland |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home 6500 York Road 21212  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>MAR 02 1987 REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |  |  |

①

MAR 03 1957  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

03912

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

John

L.

Sloan

2a. DATE KNOWN  
OF ESTI-  
DEATH MATED

☒ MONTH DAY YEAR  
2 12 1987

2b. HOUR  
M

3. SEX  
M

4. RACE  
W

5. DATE OF BIRTH  
MONTH DAY YEAR  
3/10/03

6. AGE (IN YEARS  
LAST BIRTHDAY)  
83 YRS.

IF UNDER 1 YR.  
MONTHS DAYS

IF UNDER 24 HRS.  
HOURS MIN.

7c. DATE  
PRONOUNCED  
DEAD

2 12 1987

2d. HOUR  
M

7b. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

MD

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County, MD

10. CITY OR TOWN OF DEATH

Towson

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

St. Joseph's Hospital

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Sales

12b. KIND OF BUSINESS  
OR INDUSTRY

Cement

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. CITY

Balto.

13c. CITY OR TOWN

Ruxton

13d. INSIDE CITY LIMITS?  
YES ☐ NO ☒

13e. STREET ADDRESS

7001 N. Charles St., 21204

14. FATHER'S NAME

Robert

MIDDLE

N.

LAST

Sloan

15. MOTHER'S MAIDEN NAME

Louise

MIDDLE

Littig

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

219 03 3687

17. INFORMANT

ADDRESS

Dorothy S. Atkinson, Riderwood, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease with

~~XXXXXXXXXXXXXXXXXXXX~~

Conditions, if any, which  
gave rise to immediate  
cause (c) stating the under-  
lying cause lost.

xxx incarcerated hernia

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion  
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

*William M. Zane*

TITLE (SPECIFY)

M.D. Assistant

MEDICAL EXAMINER

DATE  
SIGNED

2/13/87

EXAMINER'S NAME  
(TYPE OR PRINT)

William M. Zane, M.D.

ADDRESS

111 Penn St. Balto. MD.

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

2/16/87

23c. NAME OF CEMETERY OR CREMATORY

New Cathedral

23d. LOCATION  
CITY OR TOWN

Balto.,

COUNTY

MD

24. FUNERAL DIRECTOR  
NAME

Henry W. Jenkins & Sons Co.

4905 York Road

Balto., MD

21212

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

FEB 17 1987

*Julia Davidson-Randall*

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A PERMIT TO TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 B4  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

CONFIDENTIAL

1

SECRET

USA

CONFIDENTIAL

CONFIDENTIAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

CHARLES J. SMID

REG. NO.

|   |  |   |  |  |  |   |  |                                      |  |
|---|--|---|--|--|--|---|--|--------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 2a DATE OF DEATH   |  | MONTH DAY YEAR  |  | 2b HOUR                              |  |
| Charles   |  | Smid  |  | 2-25-87  |  | 7:45 P.M.   |  |                                      |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | IF UNDER 1 YEAR                      |  |
| MALE  |  | White   |  | 10/9/00  |  | 86 YRS.   |  | MONTHS DAYS HOURS MIN.               |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                                      |  |
| New York  |  | USA   |  |  |  | Baltimore County MD   |  |                                      |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |                                      |  |
| Balto.  |  | MANOR CARE - Rossville  |  | Mechanic   |  | Elevator Co.  |  |                                      |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 13b COUNTY  |  | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?   |  | 13e STREET ADDRESS / ZIP CODE        |  |
| Md.   |  | Balto.  |  | Balto.   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 4523 Wishal Dr. 21236                |  |
| 14 FATHER'S NAME  |  | 15 MOTHER'S MAIDEN NAME   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS                 |  |
| Unknown   |  | Unknown   |  | No   |  | 085-01-2976   |  | Edwin C. Smid, 4523 Wishal Dr. 21236 |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arrhythmia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Senile Dementia, Psychosis, Reversible</u>   |  |   |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?  |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM ETC)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a I certify that (1) this hospital attended the deceased from <u>Feb 1</u> 19 <u>87</u> to <u>Feb 25</u> 19 <u>87</u> that (2) we lost saw the deceased alive on <u>Feb 25</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  | 22b SIGNATURE<br><u>John H. B. O.</u><br>DEGREE <u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><u>2-26-87</u>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e ADDRESS   |  |   |  |
|  |  |   |  |   |  |

|   |  |          |  |                                   |  |   |  |
|---|--|----------|--|-----------------------------------|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)                            |  | 23b DATE |  | 23c NAME OF CEMETERY OR CREMATORY |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Cremation   |  | 2/28/87  |  | Greenmount Crematory              |  | Balto., Md.                               |  |
| 24 FUNERAL HOME (NAME AND ADDRESS)                                  |  |          |  | 25a DATE REC'D. BY REGISTRAR      |  | 25b REGISTRAR'S SIGNATURE                 |  |
| Schimunek Funeral Home, Inc.<br>9705 Belair Road, Balto., Md. 21236 |  |          |  | MAR 03 1987                       |  | Julia Davidson-Randall                    |  |

100% Cotton 4188B

MAINTAIN



BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page requires certain copyers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  | REG. NO.  |  |
|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>George Russell Smith</b>  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>February 2, 1987</b>     |  |
| 3 SEX<br><b>Male</b>  |  |   |  |  | 7b HOUR<br><b>7:20 PM</b>                                       |  |
| 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 17 1900</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS  |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rossville 21237</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Sq. Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD   |   |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Route Salesman</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Linen Co.</b>  |  |  |   |  |
| 13a STATE<br><b>Maryland</b>  |  | 13b CITY OR TOWN<br><b>Baltimore</b>  |  | 13c STREET ADDRESS / ZIP CODE<br><b>5 "A" Maidstone Ct. 21237</b>  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b SOCIAL SECURITY NO.<br>(# YES, GIVE WAR OR DATES)<br><b>-</b>   |  | 17 INFORMANT ADDRESS<br><b>Theodore J. Smith, Son Balto., Md. 21221</b>  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10 years</b>   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>  |  |   |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/13</b> 19 <b>71</b> to <b>2/2</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>7-13</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>MORRIS RAINESS, MD.</b>  |  | DEGREE<br><b>MD.</b>  |  | 22c. DATE SIGNED<br><b>2-3-87</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MORRIS RAINESS, MD.</b>   |  | 22e ADDRESS<br><b>1105 Old Eastern Ave 21221</b>  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(CHECK)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/4/87</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Pk.</b>  |   |  |
| 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>Baltimore, Md.</b>   |  |   |  |  |   |  |
| 24 FUNERAL DIRECTOR<br><b>Brazdzinski Funeral Home</b>  |  | 25a DATE REC'D. BY REGISTRAR<br><b>FEB 5 1987</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>Julia Swenson-Rodgers</b>  |   |  |

21221

100-100000

February 2, 1968

George Marshall

Salisbury County

x

USA

South American Lines Co.

Washington - Hospital

Washington - DC

U.S. Air Force Co. 1953

x

Washington

Washington

Washington

Unknown

Unknown

The American  
Theodore J. Smith, son of  
Theodore J. Smith, son of  
Theodore J. Smith, son of

214 of 202

0 -

10

Salisbury, Md.

Washington, Md.

Washington, Md.

Washington, Md.

Washington, Md. 100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver this permit to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |                          |  |              |  |  | REG. NO.  |  |                                      |  |
|---|--|--|--|--|--------------------------|--|--------------|--|--|---|--|--------------------------------------|--|
| 1- FOR STATE REGISTRAR  |  |  |  |  |                          |  |              |  |  | 7 0 3 9 1 5   |  |                                      |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH        |  |              |  |  | 2b. HOUR  |  |                                      |  |
| James R SMITH   |  |  |  |  | February 6, 1987         |  |              |  |  | 10:40 A   |  |                                      |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH   |                          | 6 AGE (IN YEARS LAST BIRTHDAY)   |              | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.  |  |                                      |  |
| Male  |  | White  |  | June 16 1921   |                          | 65   |              | MONTHS DAYS  |  | HOURS MIN.  |  |                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH   |              |  |  |   |  |                                      |  |
| New York  |  | USA  |  |  |                          | Baltimore County MD.   |              |  |  |   |  |                                      |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                          |  |              |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |
| Rossville   |  | Franklin Square Hospital   |  |  |                          |  |              |  |  |   |  |                                      |  |
| 13a. STATE  |  |  |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN  |              | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  | 13e. STREET ADDRESS / ZIP CODE       |  |
| Md.   |  |  |  | Baltimore  |                          | Essex  |              |  |  |   |  | 600NewJerseyAve. 21221               |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME |  |              |  |  |   |  |                                      |  |
| George Smith  |  |  |  |  | Isabella McGinney        |  |              |  |  |   |  |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO. |  | 17 INFORMANT |  |  |   |  | ADDRESS                              |  |
| yes   |  |  |  |  | WW1                      |  | 579-12-8139  |  |  |   |  | Dorothy Smith 600NewJerseyAve. 21221 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                      |  |  |  |  |                          |  |              |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |  |                          |  |              |  |  |   |  |                                      |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          |  |              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |              |  |  |   |  |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |              |  |  |   |  |                                      |  |
| 22a. I certify that (X) (this hospital) attended the deceased from February 6, 1987, to February 6, 1987, that (X) (we) last saw the deceased alive on February 6, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) die on February 6, 1987. |  |  |  |  |                          |  |              |  |  |   |  |                                      |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |                          |  |              | 22c. DATE SIGNED   |  |   |  |                                      |  |
| Paul Tecklenberg M.D.   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |                          |  |              | 2-6-87   |  |   |  |                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |                          |  |              |  |  |   |  |                                      |  |
| Paul Tecklenberg M.D.   |  |  |  | 9000 Franklin Square Dr. 21237   |                          |  |              |  |  |   |  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION  |              |  |  |   |  |                                      |  |
| Burial  |  | 2/9/87   |  | BelairMemorial   |                          | Belair Harford Maryland  |              |  |  |   |  |                                      |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |                          | 25a. DATE REC'D. BY REGISTRAR  |              | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                      |  |
| ConnellyFuneralHome 300MaceAve. 21221   |  |  |  |  |                          | FEB 10 1987  |              | A. J. Anderson   |  |   |  |                                      |  |





DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(Type or print)<br>John W. Smith   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 9, 1987  |  | 2b. HOUR<br>7:45A. M.  |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 13, 1911   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Carroll Co. Md.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>3305 Chapman Road 21133 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Maintenance Hendersen Wedd Co. | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>Balto.  | 13c. CITY OR TOWN<br>Randallstown                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Smith   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Georgia Beacraft                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |  | 16b. SOCIAL SECURITY NO.<br>213-01-9004   | 17. INFORMANT<br>ADDRESS<br>Mrs. Rose E. Smith Randallstown, Md.                                   |  |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Colon Cancer</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |

MEDICAL CERTIFICATION

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 12-12-86</u> , 19 <u>86</u> , to <u>Feb. 9, 1987</u> , that (I) (we) last saw the deceased alive on <u>12-12-86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><u>Deepak Merchant</u>   |  | DEGREE<br>MD.  | 22c. DATE SIGNED<br>2-9-87 1 pm   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Deepak Merchant   |  | 22e. ADDRESS<br>3350 Wilkens Ave MD. 21229.  |   |

|  |                           |  |   |
|--|---------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial             | 23b. DATE<br>Feb. 9, 1987 | 23c. NAME OF CEMETERY OR CREMATORY<br>Lake View Memorial | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sykesville, Md. |
| 24. FUNERAL DIRECTOR<br>Eline Funeral Home Reisterstown, Md. 21136 |                           | 25. DATE FILED BY REGISTRAR<br>FEB 09 1987               |   |
|  |                           | 26. REGISTRAR'S SIGNATURE<br><u>Julia Gordon-Landess</u> |   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

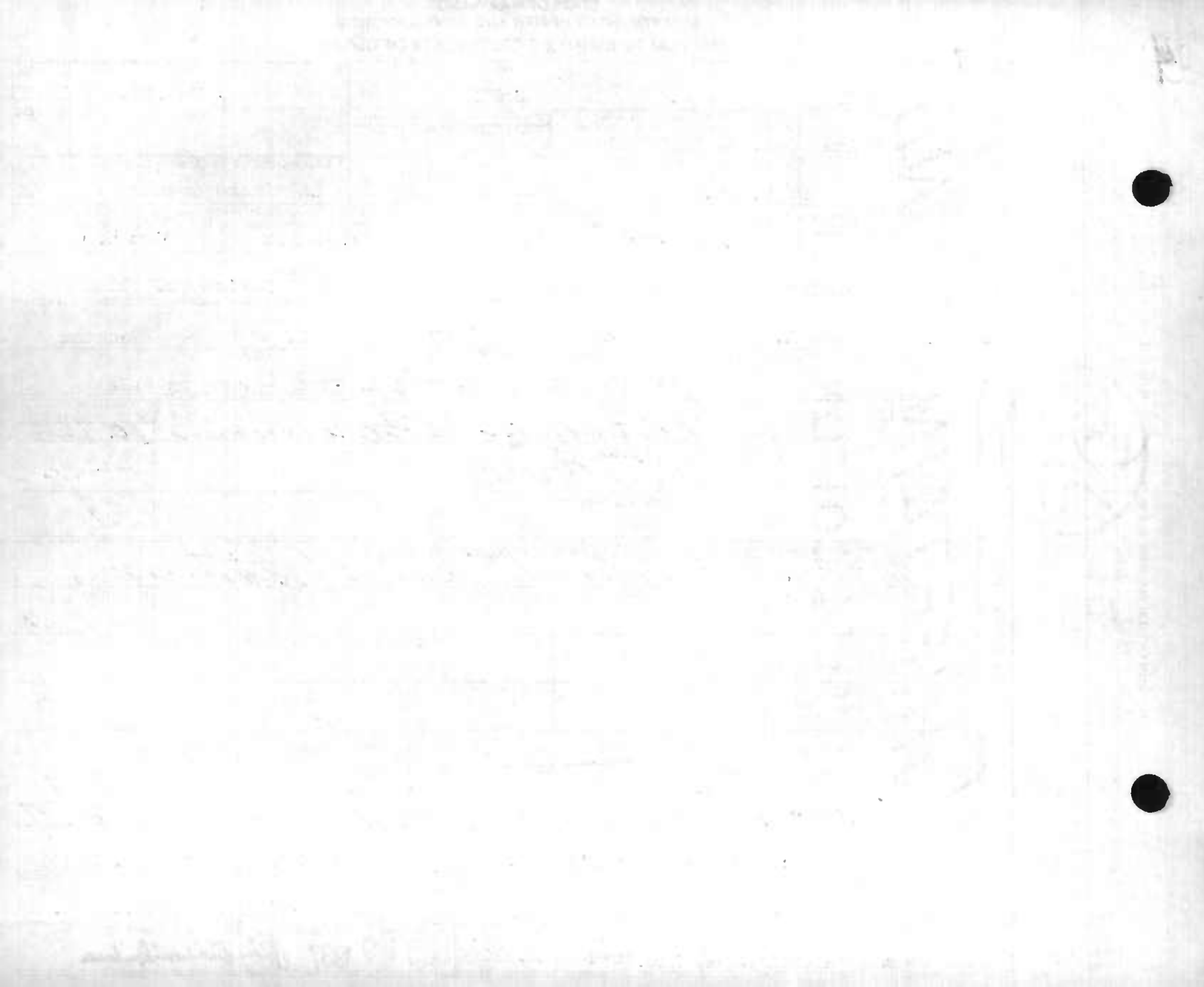
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
|---|--|---|--|---|--|---|--|--|--|--|--|--------------------------|--|-----|--|------|--|----------|--|
| 1- DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH                      |  | ESTIMATED                                    |  | MONTH                    |  | DAY |  | YEAR |  | 2b. HOUR |  |
| MARY  |  | A.  |  | SMYTH   |  |   |  | Feb. 15                                      |  | 19   |  | 87                       |  |     |  |      |  | 10:35    |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                               |  | IF UNDER 24 HRS.                             |  | 2c. DATE PRONOUNCED DEAD |  |     |  |      |  | 2d. HOUR |  |
| Female  |  | White   |  | Oct. 5, 1897  |  | 89 YRS.   |  |  |  |  |  |                          |  |     |  |      |  | M        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |  |  |                          |  |     |  |      |  | MD.      |  |
| Maryland  |  | U.S.A.  |  | WIDOWED   |  | X   |  | Baltimore County                             |  |  |  |                          |  |     |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
| Towson  |  | Stella Maris Hospice  |  | Homemaker   |  | Own Home  |  |  |  |  |  |                          |  |     |  |      |  |          |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |  |  |                          |  |     |  |      |  |          |  |
| Maryland  |  | Harford   |  | Forest Hill   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1622 Denise Dr. 21050                        |  |  |  |                          |  |     |  |      |  |          |  |
| 14. FATHER'S NAME   |  | MIDDLE  |  | LAST  |  | 15. MOTHER'S MAIDEN NAME  |  | MIDDLE                                       |  | LAST   |  |                          |  |     |  |      |  |          |  |
| Charles   |  | A.  |  | Born  |  | Mary  |  | A.   |  | Wachter                                      |  |                          |  |     |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
| No  |  | 216-48-2251   |  | Margaret A. Smyth - same as #13e  |  |   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | PART I DEATH WAS CAUSED BY:                                 |  | IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |                          |  |     |  |      |  |          |  |
|   |  |   |  | Aspiration Pneumonia  |  | AS PVK  |  | 10 hrs.                                      |  |  |  |                          |  |     |  |      |  |          |  |
|   |  |   |  | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |  | (b)   |  | 5 yrs  |  |  |  |                          |  |     |  |      |  |          |  |
|   |  |   |  | (c)   |  |   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |   |  | Photograph Enclosed   |  | Tuberculosis  |  |  |  |  |  |                          |  |     |  |      |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 20. AUTOPSY?  |  |   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
|   |  |   |  |   |  |   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                 |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                 |  |   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
|   |  | HOUR A.M. MONTH DAY YEAR                                    |  |   |  |   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  |   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
|   |  |   |  |   |  |   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on   |  | Autopsy <input type="checkbox"/>                            |  | Inspection <input checked="" type="checkbox"/>  |  | Inquiry <input type="checkbox"/>                                    |  | and in my opinion                            |  |  |  |                          |  |     |  |      |  |          |  |
| death resulted from:  |  | Natural causes <input checked="" type="checkbox"/>          |  | Accident <input type="checkbox"/>   |  | Suicide <input type="checkbox"/>                                    |  | Homicide <input type="checkbox"/>            |  | Undetermined manner <input type="checkbox"/> |  |                          |  |     |  |      |  |          |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)   |  | DATE SIGNED   |  |   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
| Charles F. O'Donnell, M.D.  |  | MEDICAL EXAMINER  |  | 2/16/87   |  |   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS   |  | 7501 York Rd., Towson, Md. 21204  |  |   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
| Burial  |  | 2-19-87   |  | Dulaney Valley  |  | Cockeysville, Balto., Md.   |  |  |  |  |  |                          |  |     |  |      |  |          |  |
| 24. FUNERAL DIRECTOR  |  | NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                   |  |  |  |                          |  |     |  |      |  |          |  |
| Ruck Towson Funeral Home, Inc.  |  | Towson, Md. 21204   |  | 1050 York Rd.   |  | FEB 19 1987   |  | Julia Tindem-Rudner                          |  |  |  |                          |  |     |  |      |  |          |  |

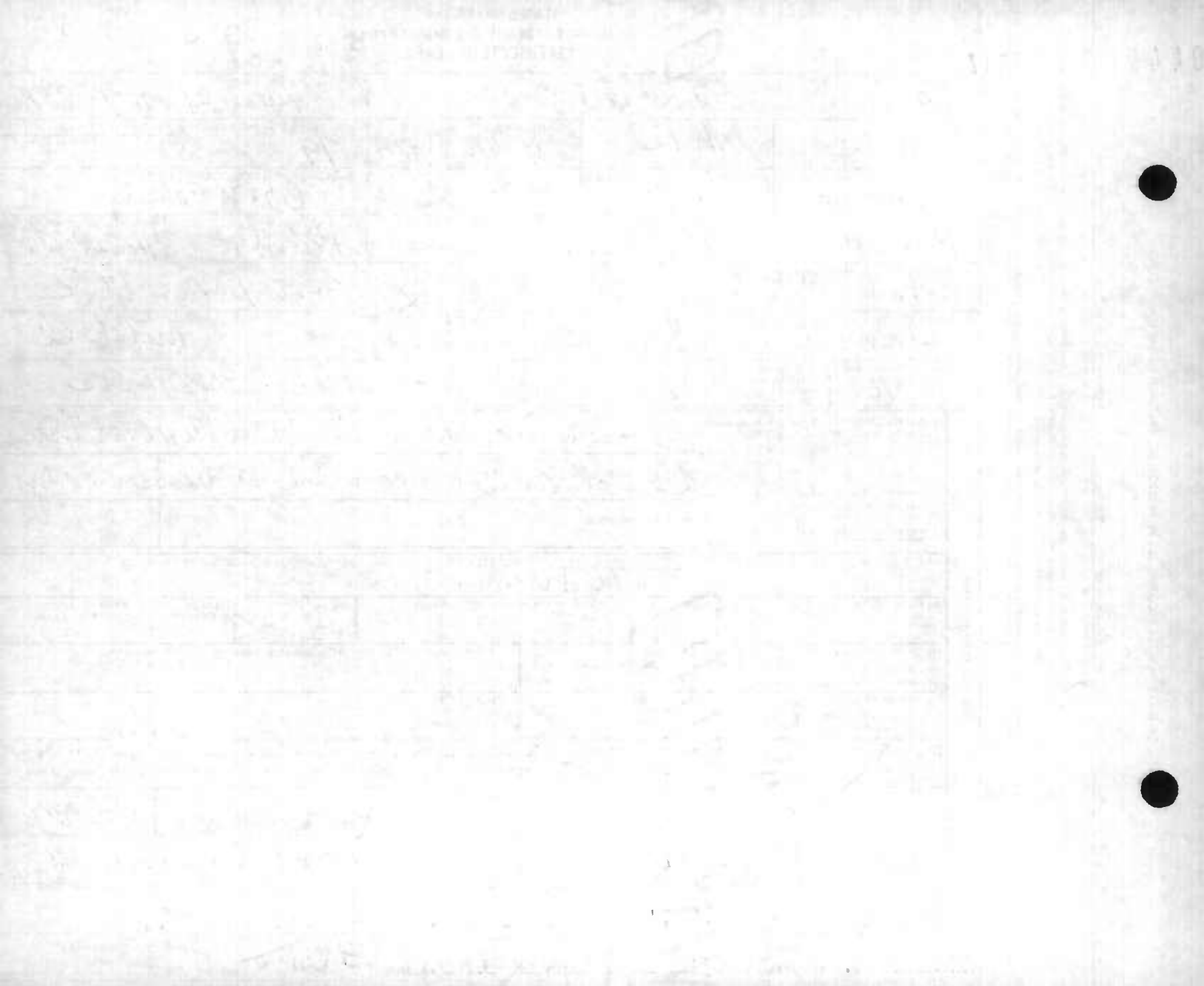


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  | 7 03918  |  | REG. NO.   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR                                     |  |
| DAVID S. SPRIGGS  |  |  |  | Feb 21 1987  |  |  |  | 8:00pm                                       |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7 UNDER 1 YEAR 7 UNDER 24 HRS                |  |
| Male  |  | White  |  | MONTH DAY YEAR<br>7 16 1907  |  | 79   |  | MONTHS DAYS HOURS MIN                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  | 10 MD  |  |
| Virginia  |  | USA  |  |  |  | Baltimore County   |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OR PRINT)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Parkville   |  | 3028 Texas Ave   |  | Painter  |  | House Painter  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |  |  |
| 13a. State  |  | 13b. County  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 3028 Texas Ave   |  |  |  |
| 14. FATHER'S NAME   |  | 15 MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS                         |  |
| Samuel B. Spriggs   |  | Susan Mitchell   |  | No   |  | 213 10 0490  |  | Wife - Janet Spriggs 3028 Texas              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|   |  | Cardiac Decompensation and Cerebral Anoxia   |  | Generalized Arteriosclerotic Cardiovascular Dis.   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  | Alzheimer Disease  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
|   |  | P.M. 19  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET   |  | CITY OR TOWN   |  | COUNTY STATE                                 |  |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 15 19 87, to Feb 21 19 87, that (I) (we) lost saw the deceased alive on Jan 15 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED                             |  |
|   |  | Frank T. Kasik Jr MD   |  |  |  |  |  | 2/21/87                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY           |  |
| FRANK T. KASIK JR MD  |  | 9005 HARBOR RD BALTO MD 21234  |  | BURIAL   |  | FEB. 24, '87   |  | MORELAND MEM. PARK                           |  |
| 24 FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 24c. LOCATION CITY OR TOWN   |  | COUNTY   |  | STATE  |  |
| WILLIAM E. JOHNSON  |  | 8521 LOCH RAVEN BLVD.  |  | BALTIMORE CO., MD  |  |  |  |  |  |
| 25a. DATE RECEIVED BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  | 25c. DATE RECEIVED BY REGISTRAR  |  | 25d. REGISTRAR'S SIGNATURE   |  |  |  |
| Feb 23 1987   |  | [Signature]  |  | Feb 23 1987  |  | [Signature]  |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03919

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ralph Edwin Standiford              |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02/23/87                                 |  | 2b. HOUR<br>1:50 PM   |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 23, 1899   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland                   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |   |
| 10. CITY OR TOWN OF DEATH<br>Towson, MD                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dulaney Towson Nursing Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ship Fitter | 12b. KIND OF BUSINESS OR INDUSTRY<br>Md. Drydock                                     |   |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>Balto.   | 13c. CITY OR TOWN<br>Timonium  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Standiford                 |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth White                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>217-01-0172   |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Evelyn A. Bangs, 9 Mulrany Ct., 21093 Timonium, Md. |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary Artery

DUE TO, OR AS A CONSEQUENCE OF

(b)

Atherosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

22a. I certify that (I) (this hospital) attended the deceased from August 19, 87, to Feb 23, 19, 87, that (I) (we) last saw the deceased alive on Feb 23, 19, 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

Neal M. Friedlander, M.D.

333 St. Paul Place, Balto., Md.

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Burial

2/26/87

Holy Cross Cemetery

Brooklyn Anne

Md.

24. FUNERAL DIRECTOR

NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. SIGNATURE

Martin D. Lawson, 10 W. Padonia Rd.

FEB 26 1987

A. J. [Signature]

BP

DHMH - 16 50M 4/83

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate and papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

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*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]*



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card bearing pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, this medical examiner must be notified at once.

## MEDICAL CERTIFICATION

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, this medical examiner must be notified at once.

DHMM - 16 60M 7/84  
(VRA 15, 4)



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03921

REG. NO.

|   |   |   |   |  |                                   |
|---|---|---|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | 2a. DATE OF DEATH   |   | 2b. HOUR   |                                   |
| Charles Steiner   |   | Feb. 1 1987   |   | 4:30 A.M.  |                                   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)   | IF UNDER 1 YEAR  |                                   |
| Male  | White   | July 2 1903   | 83 YRS.   | MONTHS DAYS HOURS MIN.   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                   |
| Bohemia   | U.S.A.  |   | Baltimore County MD.  |  |                                   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore   | Meridian Nursing Home   |   | Certified Electrician   |  | U.S. Coast                        |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE   |                                   |
| Md.   |   | Baltimore   |   | 5215 Hillburn Ave. 21206   |                                   |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME  |   |  |                                   |
| Joseph Steiner  |   | Marie unknown   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |                                   |
| no  |   | 213-03-9349   |   | Sophie Steiner (wife) same address   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic obstructive pulmonary disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alzheimer's disease, Parkinson's disease</u>  |   |   |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |   |   |   |  |                                   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |
| 22a. I certify that (I) this hospital attended the deceased from <u>12/10/86</u> to <u>2/1/87</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>2/1/87</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death. |   |   |   |  |                                   |
| 22b. SIGNATURE  |   | DEGREE  |   | 22c. DATE SIGNED   |                                   |
| <u>Carl Friedman</u>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   | 2/2/87   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |   |  |                                   |
| Dr. Carl Friedman   |   | 660 Kenilworth Drive  |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION   |  |                                   |
| Burial  | 2/3/87  | Gardens of Faith  | Baltimore County Md.  |  |                                   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |   |   | 25a. DATE REC'D. BY REGISTRAR   |  |                                   |
| Schimunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213  |   |   | FEB 3 1987  |  |                                   |
|   |   |   | 25b. REGISTRAR'S SIGNATURE  |  |                                   |
|   |   |   | <u>Julia Davidson-Randall</u>   |  |                                   |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner, not a hospital doctor, must sign at time of death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the funeral director. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8703922   |  |   |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (Type or Print)<br>FIRST MIDDLE LAST<br>ELOISE G. STORZ   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEB. 01, 1987   |  |  |  | 2b. HOUR<br>M  |  |   |  |
| 3 SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOV. 04, 1898   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO. MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CO. MD.                            |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>COCKEYSVILLE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>316 CRANBROOK ROAD |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PIANO INSTRUCTOR |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.  |  |   |  | 13b. COUNTY<br>BALTO. CO.   |  | 13c. CITY OR TOWN<br>COCKEYSVILLE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>316 CRANBROOK RD. 21030 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRANCIS H. GROSS   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LAURA SHIELDS WYATT  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>577-84-5272  |  | 17. INFORMANT<br>ADDRESS<br>FAMILY RECORDS  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASCVD   |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>YEARS  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)  |  |   |  |   |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>ORGANIC BRAIN SYNDROME   |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>[Signature]  |  |   |  | DEGREE<br>MD  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>2-2-87                                |  |
| 22d. PHYSICIAN'S NAME (Type or Print)<br>NATHAN ROSENBLUM  |  |   |  | 22e. ADDRESS<br>7600 OSLER DRIVE, TOWSON  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(Type or Print)<br>BURIAL   |  | 23b. DATE<br>2-5-1987   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GETTYSBURG NAT. CEM.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>GETTYSBURG PENN.                       |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>EVANS CHAPEL OF CHIMES TIMONIUM, MD  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 3 1987   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |   |  |

RECEIVED  
FEB 2 1964

3

FEB 3 1964

TO HOSPITAL OR ATTENDING PHYSICIAN, The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. The permit should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |  |   |  | REG. NO.   |  |
|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Effie J. Strominger</b>   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-20-87</b>   |  | 2b. HOUR<br>MIN.<br><b>12:18 PM</b>                              |  |
| 3 SEX<br><b>FEMALE</b>   | 4 RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT. 26 1896</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CO. MD.</b>   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PERRING PARK NURSING HOME</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>—</b> 13c. CITY OR TOWN <b>BALTIMORE</b>   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3723 HUDSON ST. - 21224</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES VOYCE</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE UNKNOWN</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>213-34-6569</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>GEORGE STROMINGER 2502 CHILBIRBY RD 21085</b>   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Generalized, Senile ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>74 yrs.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 m</b> |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>—</b>  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-2-81</b> to <b>2-20-87</b> , that (I) (we) last saw the deceased alive on <b>2/19-87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>James Punzalan</b>  |   | DEGREE   |   | 22c. DATE SIGNED<br><b>2/20/87</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Punzalan</b>  |   | 22e. ADDRESS<br><b>5214 HUNTER RD. BALTO. 21214</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>FEB. 23 1987</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN CEM</b>  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>   |   | 23e. DATE REC'D. BY REGISTRAR<br><b>FEB 20 1987</b>  |   | 23f. REGISTRAR'S SIGNATURE<br><b>Julia...</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>LILLY &amp; ZEILER, INC. 7005 CONKLING ST. 21224</b>  |   |  |   |  |  |  |





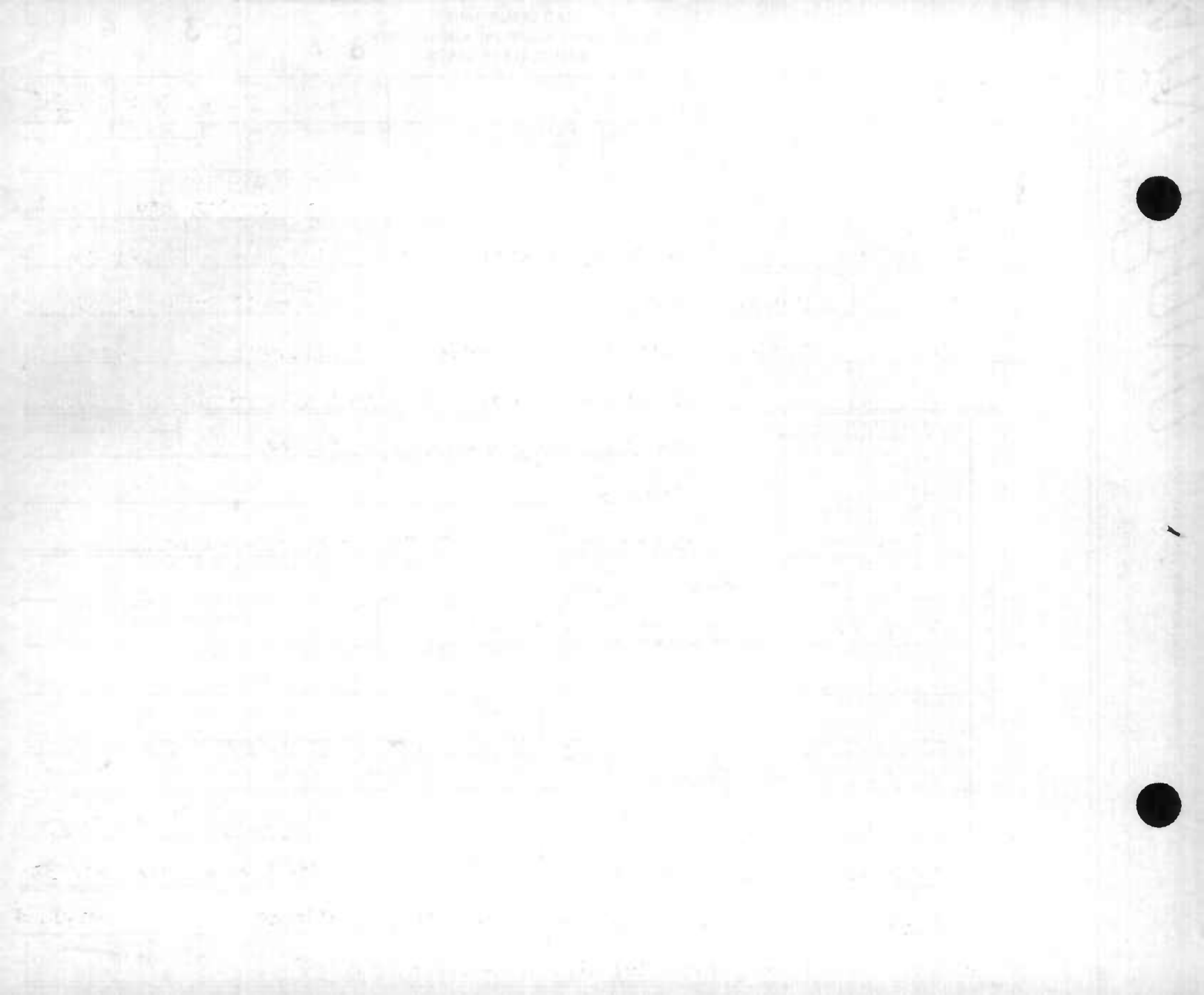
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |   |                                   |  |  |  |
|--|--|---|--|--|--|--|---|-----------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |  |   |                                   |  |  |  |
| REG. NO. 03924   |  |   |  |  |  |  |   |                                   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST MIDDLE LAST  |  |  | 2a. DATE OF DEATH  |   |                                   | MONTH DAY YEAR   |  |  |
| BURNETT ERNEST STROTT  |  |   |  |  |  | 2-21-87  |   |                                   | 2b. HOUR<br>1:25 M   |  |  |
| 3 SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                   |   | IF UNDER 1 YEAR                   |  | IF UNDER 72 HRS                              |  |
| MALE   |  | WHITE   |  | MONTH DAY YEAR<br>1 16 01  |  | 86 YRS   |   | MONTHS DAYS                       |  | HOURS MIN.                                   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |   |                                   |  |  |  |
| Maryland   |  | U.S.A.  |  |  |  | Baltimore County MD.   |   |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| Randallstown   |  | Baltimore County General Hospital   |  |  |  | Salesman   |   | Turner Co.                        |  |  |  |
| 13a. STATE   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |                                   | 13e. STREET ADDRESS / ZIP CODE                                 |  |  |
| Maryland   |  |   | Baltimore  |  | Woodlawn   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 2609 Purnell Drive 21207                                       |  |  |
| 14. FATHER'S NAME  |  |   | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |                                   |  |  |  |
| FIRST MIDDLE LAST<br>John Charles Strott   |  |   | FIRST MIDDLE LAST<br>Marie Elizabeth Reus  |  |  |  |   |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |                                   |  |  |  |
| NO   |  |   | 212-01-2863  |  | Leonard E. Strott 4810 Topping Rd. 20852                                       |  |   |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>MESENTERIC THROMBOSIS LEADING TO</u><br>GANGRENOUS BOWEL                                    |  |   |  |  |  |  |   |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |  |  |  |   |                                   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 2-18-87  |  |   | MESENTERIC THROMBOSIS GANGRENOUS BOWEL   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |                                   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |                                   |  |  |  |
|  |  |   |  |  |  |  |   |                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-15</u> 19 <u>87</u> to <u>2-21</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2-21</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |   |                                   |  |  |  |
| 22b. SIGNATURE   |  |   | DEGREE   |  |  |  |   |                                   | 22c. DATE SIGNED   |  |  |
|  |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  |   |                                   | 2-21-87  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   | 22e. ADDRESS   |  |  |  |   |                                   |  |  |  |
| ORLANDO B. CONNORS M.D.  |  |   | 2064 - RANDALLSTOWN AVE. 21133   |  |  |  |   |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |                                   | CITY OR TOWN COUNTY STATE                                      |  |  |
| Burial   |  |   | 2/24/87  |  | Loudon Park Cemetery   |  | Baltimore   |                                   | Maryland   |  |  |
| 24. FUNERAL DIRECTOR   |  |   | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE                                       |   |                                   |  |  |  |
| NAME ADDRESS<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.   |  |   | 21229  |  |  | FEB 24 1987  |   |                                   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>WILEY J STUART</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 14 87</b>                     |  | 2b. HOUR<br><b>7:21 AM</b>  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 7 33</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>YRS</b>                              |  | IF UNDER 24 HRS. HOURS MIN.<br><b>MD</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA - NC</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>   |  | 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St Joseph Hospital</b>                      |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b>                      |  | 13a. STATE<br><b>Maryland</b>   |  |
| 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Barnett Stuart</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sallie Phillippi</b>  |  | 16. SOCIAL SECURITY NO.<br><b>231-42-1615</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>231-42-1615</b>                         |  | 17. INFORMANT ADDRESS<br><b>Mrs. Emma Stuart - Same as #13</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cirrhosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         |  | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 14</b> , 19 <b>87</b> , to <b>Feb 14</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>Feb 14</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |  |  |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAROLD C. RAZ</b>   |  | 22c. ADDRESS<br><b>St. Joseph Hospital</b>                             |  | 22d. DATE SIGNED<br><b>2/14/87</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>2-14-87</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>State Anatomy Board</b>  |  | 24b. ADDRESS<br><b>Balto., Md.</b>                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 20 1987</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  | 25c. DATE REC'D. BY REGISTRAR<br><b>FEB 20 1987</b>                    |  | 25d. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13544

202

Handwritten notes and diagrams on lined paper. The text is mostly illegible due to fading and bleed-through. Some visible words include "NOTICE" and "RECEIVED". There are several large, stylized handwritten marks or signatures, including a prominent one in the center that appears to be "RECEIVED".



2020

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03920

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |                               |
|--|---|---|---|--|-------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John Henry Sullivan   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2-20-87  |  | 2b. HOUR<br>1305 PM           |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 11 1900   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86<br>YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS                                   | IF UNDER 24 HRS<br>HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |                               |
| 10. CITY OR TOWN OF DEATH<br>Balto. County   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret-Switchboard             | 12b. KIND OF BUSINESS OR INDUSTRY<br>Sun Cab                     |                               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>200 Middleway Rd. Apt. 2 21220 |                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Sullivan   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Kate Frock   |   |  |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-01-7078  | 17. INFORMANT<br>ADDRESS<br>Balto., Md. 21220<br>Marie F. Sullivan 200 Middleway Rd. Apt. 2   |   |  |                               |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHIMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-11</u> 19 <u>87</u> , to <u>2-20</u> 19 <u>87</u> that I (we) last<br>saw the deceased alive on <u>2-20</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><u>R. Girgis</u>  | DEGREE   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><u>2-20-87</u>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Raafat Y. Girgis</u>  |  | 22e. ADDRESS<br><u>Baltimore County Hosp.</u>  |   |

|   |                      |   |  |
|---|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial      | 23b. DATE<br>2-24-87 | 23c. NAME OF CEMETERY OR CREMATORY<br>Belair Mem. Gardens | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Harford Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Lassahn Funeral Home</u> |                      | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 25 1987</u>       | 25b. REGISTRAR'S SIGNATURE<br><u>Julia D. [Signature]</u>      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in the funeral director's office, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above (injury) or other traumatic event, the medical examiner must be notified at once.

ON A VARIETY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed with the funeral director's office. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, a coroner's inquest may be required. In such an event, the medical examiner's office should be notified.

44211 FEB 17 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |   |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Matilda Mary SUNDERLAND             |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 14, 1987 |   |   | 2b. HOUR<br>8:15p<br>M   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>March 23, 1918 <sup>AR</sup>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Franklin Sq. Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OR BUSINESS, INDUSTRY OR SERVICE, OR PART OF WORKING LIFE)<br>Presser |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Laundry |  |
| 13a. STATE<br>Maryland   |  |  | 13b. CITY OR TOWN<br>Baltimore                           |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS, ZIP CODE<br>18 A Glenwood Rd. 21221 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George H. Dunn                   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose Ychle                                     |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  |  | 16b. SOCIAL SECURITY NO.<br>214 24 9011                  |   | 17. INFORMANT<br>ADDRESS<br>John Sunderland, Husband Same                                       |  |  |  |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Pancreatic tumor<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

|   |  |  |  |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from February 8, 1987, to February 14, 1987, that (I) (we) last saw the deceased alive on February 14, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br>I. Gouni  |  | 22c. DATE SIGNED<br>2/14/87  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>I. Gouni   |  | 22e. ADDRESS<br>9000 Franklin Sqaure Drive   |  |

|  |  |                      |  |   |  |  |  |
|--|--|----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial                                      |  | 23b. DATE<br>2/18/87 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Memorial Gardens |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md. |  |
| 24. FUNERAL DIRECTOR<br>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave 21221 |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 17 1987                      |  | 25b. REGISTRAR'S SIGNATURE                                       |  |





45494 FEB 27 87

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03928

REG. NO.

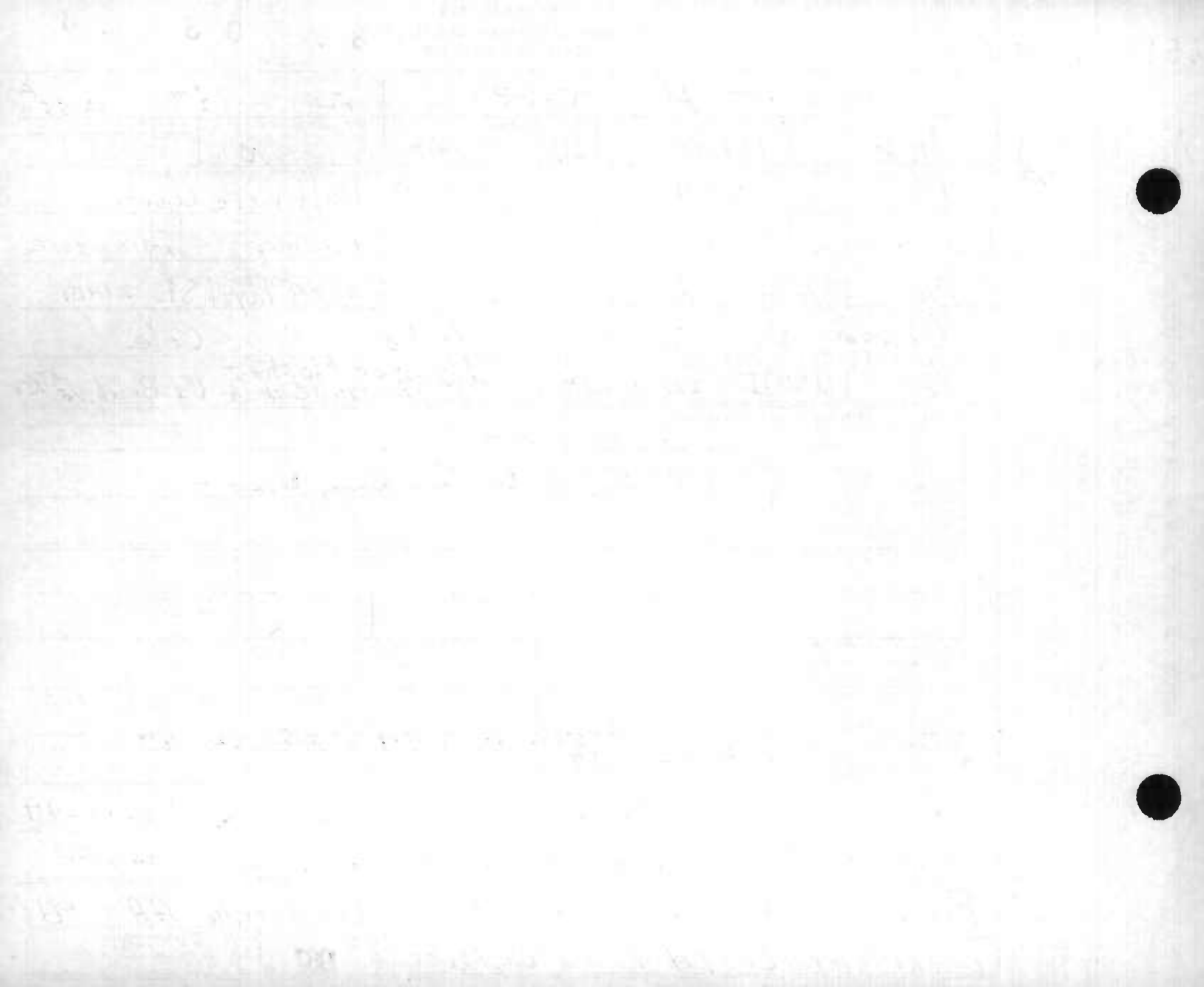
|   |  |  |  |   |                                |  |
|---|--|--|--|---|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ROBERT M. TAPP  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 22, 87 |   | 2b. HOUR<br>12:55 <sup>A</sup> |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan 1917  |                                |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.   |                                |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                |  |
| 9. CITY OR TOWN OF DEATH<br>Randallstown  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore Co. General |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |                                |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12b. STATE<br>Md.   |  | 13a. CITY OR TOWN<br>Hannapolis  |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George E. Tapp  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Allie Cole  |  | 13c. STREET ADDRESS ZIP CODE<br>908B Royal St. 21401  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAY OR DATES)<br>WW II 228-10-0374  |  | 17. INFORMANT<br>Name Address<br>Kleanor Mosher<br>909 Thousand Oaks Dr. U.S. Beach, Va. 23067  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>chronic obstructive lung disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |   |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 13, 1987</u> , to <u>Feb. 22, 1987</u> , that (I) (we) last saw the deceased alive on <u>Feb. 22, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                                      |  |  |  |   |                                |  |
| 22b. SIGNATURE<br>Sharon Pournmotabbed, M.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  |  | 22c. DATE SIGNED<br>2-22-87   |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GHASSEM POURMOTABBED   |  |  |  | 22e. ADDRESS<br>Baltimore Co. General Hospital  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  | 23b. DATE<br>2-25-87   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lakemont  |                                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Davidsonville AA MD   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Zylor Funeral Chapel Annapolis, Md   |  |   |                                |  |
| 25a. DATE REC'D. BY REGISTRAR<br>FEB 26 1987  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Gordon-Rudolph   |  |   |                                |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03929  
REG. NO.

1- FOR  
STATE  
REGISTRAR

044047 FEB 13 1987

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>ANNA B TAYLOR</b>   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/11/87</b>   |  | 2b HOUR<br><b>3:19 PM</b>  |  |
| 3 SEX<br><b>FEMALE</b>   |  | 4 RACE<br><b>W</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03/05/22</b>   |  |
| 6a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC; 6701 N. CHARLES ST.</b> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired-Balto.Co.</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a STATE<br><b>Maryland</b>   |  | 13b COUNTY<br><b>Baltimore</b>   |  | 13c CITY OR TOWN<br><b>Owings Mills</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter H. Warren</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Fields</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br><b>220-12-6975</b>  |  | 17 INFORMANT<br><b>Anna Jean Morris</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEVERE ELECTROLYTE IMBALANCE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DIABETIC KETOACIDOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>METASTATIC LARGE CELL CARCINOMA OF THE LUNG</b>   |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY:<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |
| 22b SIGNATURE<br><i>Leslie L. Walters M.D.</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |  | 22c DATE SIGNED  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LESLIE L. WALTERS, M.D.</b>   |  | 22e ADDRESS<br><b>GBMC; 6701 N. CHARLES ST.: BALTO 21204</b>   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b DATE<br><b>2-12-87</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Carroll Cremation</b>  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ET's Funeral Home Reisterstown, Md.</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hampstead Carroll Md.</b>  |  | 25a DATE RECD. BY REGISTRAR<br><b>FEB 13 1987</b>  |  |
|  |  |  |  | 25b REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rudolph</i>   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

FEB 12 1961

RECEIVED FEB 12 1961

CHILD WELFARE



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |  |   |   |   |
|--|---|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ROBERT W. TEGTMEIER   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 2, 1987   |   | 2b. HOUR<br>4:00P <sub>M</sub>  |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>APRIL 12, 1915   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ILLINOIS  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.             |   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1121 GREEN ACRE ROAD 21204 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ENGINEER                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>MECHANIC                             |   |
| 13a. STATE<br>MARYLAND   | 13b. COUNTY<br>BALTIMORE  | 13c. CITY OR TOWN<br>21204   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>1121 GREEN ACRE RD. 21204               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HENRY CARL TEGTMEIER   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HATTIE L. FAULKENBERG   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----<br>321-07-4875  |   | 17. INFORMANT<br>ADDRESS<br>DESSIE M. TEGTMEIER TOWSON, MD 21204          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) LUNG CANCER, METASTATIC TO LIVER   |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>(6 MONTH)  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |   |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |   |  |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If we) (did) did not view the body after death. |   |  |   |   |   |
| 22b. SIGNATURE<br>NATHAN M. ROSENBLUM, M.D.  |   | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>2/3/87  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS<br>7600 OSLER DRIVE 21204 828-1323  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  | 23b. DATE<br>FEB. 6, '87  | 23c. NAME OF CEMETERY OR CREMATORY<br>DULANEY VALLEY MEM GAR.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CO., MD           |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>WILLIAM E. JOHNSON   |   | ADDRESS<br>8521 LOCH RAVEN BLVD.   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 03 1987                              | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then place remaining card in envelope. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other significant event, the medical examiner must be notified at once.

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FEB 02 1971

043022 FEB-58

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARIE CATHERINE TERRY</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 2, 1987</b>                       |  | 2b. HOUR<br><b>M</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 14, 1922</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS                               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>157 Stanmore Rd.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>XX</b>                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Adam Diacont</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret O'Leary</b>             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-12-4039</b>   | 17. INFORMANT ADDRESS<br><b>Robert L. Terry, Sr. Same</b>                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic Breast Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 months</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 19, 1987</b> , to <b>Feb. 2, 1987</b> , that (I) (we) last saw the deceased alive on <b>Feb 1, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                    |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Charles A. Padgett M.D.</b>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>2/4/87</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles A. Padgett, M.D.</b>   |  | 22e. ADDRESS<br><b>5601 Loch Raven Blvd. Baltimore, Md. 21239</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2/5/87</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Balto. Co., Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto., Md. 21212</b>   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |

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FEB 4 1987





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the nonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 03932  |                               |
|--|--|--|--|---|-------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Elenora S. Thomas  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 10, 1987   |   | 2b. HOUR<br>11:10 p.m.        |
| 3 SEX<br>Female  | 4 RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>February 3, 1921   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS                          | IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, County MD   |   |                               |
| 10. CITY OR TOWN OF DEATH<br>Dundalk   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7620 Cedar Road |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home           |                               |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Dundalk   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            | 13e. STREET ADDRESS / ZIP CODE<br>7620 Cedar Road 21222 |                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Konopacki   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ida Dembny  |  |   |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-12-5872   | 17. INFORMANT<br>ADDRESS<br>Glenn C. Thomas 7620 Cedar Road 21222  |  |   |                               |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ovarian carcinoma with</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>metastases</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>30 mo</u> |  |  |  |   |                               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><u>Rheumatic Heart Disease</u>  |  |  |  |   |                               |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |                               |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME - STREET - FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |                               |
| 22a. I certify that (1) this hospital attended the deceased from <u>June 19 72</u> to <u>2-10 87</u> , that (1) (we) last saw the deceased alive on <u>2-9 87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.  |  |  |  |   |                               |
| 22b. SIGNATURE<br><u>W. Wyman K. Womack</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br><u>2-11-87</u>                      |                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>WYMAN K Womack</u>   |  | 22e. ADDRESS<br><u>6730 Holabird Ave 21222</u>   |  |   |                               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>2-14-87   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |   |                               |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck Funeral Home of Dundalk  |  | 25a. DATE RECD. BY REGISTRAR<br>FEB 17 1987  | 25b. REGISTRAR'S SIGNATURE<br><u>John Anderson-Kandau</u>  |   |                               |

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Handwritten text at the top of the page, mostly illegible due to fading. Some words like "The" and "of" are visible.

Handwritten text in the middle section, including a line that appears to say "The first of these".

Handwritten text at the bottom of the page, including a line that appears to say "The second of these".

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. The deceased must have been dead for at least 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03933

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |   |  |  |
|---|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDWINA H. THOMPSON</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 - 8 - 1987</b>               |   |  | 2b. HOUR<br><b>2:30 A.M.</b>  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 16, 1895</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>2 30</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b> MD.                                |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Lutherville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>22 Oakridge Ct. 21093</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Hanlon</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Jane Kelly</b>  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-03-2341D</b>   |  | 17. INFORMANT ADDRESS<br><b>Edwina T. Reeve - same as #13e</b>                                  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADVANCED ARTERIO SCLEROTIC VASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CACHEXIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/10</b> 19 <b>80</b> to <b>2/8</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2/4/87</b> 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                      |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>EDDIE NAKHUDA, M.D.</b>  |  |  | 22c. DEGREE<br><b>STELLA MARIS - 2300 DULANEY VALLEY RD. TOWSON, MD.</b> |   |  | 22d. ADDRESS  |   | 22e. DATE SIGNED<br><b>2-8-87</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>2-10-87</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cemetery</b>              |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                      |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 03934  
REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Kazie Belle Thompson</i>  |  | 7a. DATE OF DEATH MONTH DAY YEAR<br><i>Feb 23 1987</i>  |  | 7b. HOUR<br><i>5:30 A.M.</i>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>Jan. 1 1905</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Towson</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice, Towson, Md</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaker</b>  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Monkton</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Deel</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Pearl Obenshain</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>15831 Carroll Rd. Monkton 21111</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-30-1171</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. Quinton D. Thompson, 1600 Jeffers RD. Towson 21204</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Stroke</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Advanced Arteriosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>May 1, 1986</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May 1, 1986</i> to <i>Feb 22 1987</i> , that (I) (we) last saw the deceased alive on <i>Feb 22 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Eddie Nakhuda</i>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><i>2/23/87</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS<br><i>Stella Maris</i>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/26/87</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Clynmalira Ch. Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>J. E. Lowell Lemmon</i> ADDRESS <i>10 W. Padonia Rd.</i>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1987</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Dendron-Randall</i>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon of page 1. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | 87 03935                                     |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |  |  |   |  |  |  |  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Agnes   |  | MIDDLE<br>MARIE  |  | LAST<br>Torrence  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02 28 87  |  | 2b. HOUR<br>4:55 A.M.                        |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 26 79   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 7b. IF UNDER 24 HRS<br>HOURS MIN.            |  |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>6211 Marietta Ave. 21214   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Granadier   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edna Eline  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> NO <input type="checkbox"/> [IF YES, GIVE WAR OR DATES] |  | 16b. SOCIAL SECURITY NO.<br>219-28-7057   |  | 17. INFORMANT ADDRESS<br>Mr. Robert J. Torrence Same as #13e   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Septic Shock<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) } |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18.   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Adel S. El-Hennawy   |  |  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>2-28-87  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Adel S. El-Hennawy  |  |  |  | 22e. ADDRESS<br>STJH.  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3-3-87  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc.  |  |  |  | ADDRESS<br>Baltimore, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 02 1987  |  | 25b. REGISTRAR'S SIGNATURE<br>Lisa Anderson-Rucker   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 87 03936<br>REG. NO.  |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Elizabeth C. Toston  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2-4-87  |  |   |  | 2b. HOUR<br>6:37 P. <sub>M</sub>   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2-4-05   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. City  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dulaney Towson Nursing Home |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Avon Sales                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>2512 E. Joppa Rd.-21234  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Nagy  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Helen   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>214-24-8406   |  | 17. INFORMANT ADDRESS<br>Elizabeth T. Bon - 2512 E. Joppa Rd.-21234                             |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Generalized ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>5 yrs</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>12 Days</u>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1</u>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>24 January 1987</u> to <u>4 February 87</u> that (I) (we) last saw the deceased alive on <u>4 February 1987</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>John C. Miller, Inc.</u><br>DEGREE<br>PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |   |  | 22c. DATE SIGNED<br><u>2/5/87</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   |  |   |  | 23b. DATE<br>2-6-87   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National Cem.  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |  |   |  |   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>John C. Miller, Inc.-6415 Belair Rd.-21206              |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>FEB 6 1987   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Gordon-Randall</u>                                       |  |  |  |



1000 MIN. 1000

9381 1000

Handwritten notes and signatures, including the word "RECEIVED" and various illegible scribbles.

045649 MAR 28

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |   |  |  |  |  |
|--|--|---|---|---|---|--|--|--|--|
| FOR STATE REGISTRAR  |  |   |   |   | REG. NO. 87 03937   |  |  |  |  |
| 1. DECEASED NAME<br>[TYPE OR PRINT] <b>William TRAUTWEIN</b>   |  |   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>FEBRUARY 24 87</b>                                       |  |  | 2b. HOUR<br>9 <sup>15</sup> M  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUC.</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>3 - 20 - 10</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore Co.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7110 GERMAN Hill Rd</b> |   |   |   | 12a. USUAL OCCUPATION<br>(NATURE OF WORK FOR MOST OF WORKING LIFE)<br><b>TAXI DRIVER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto City</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>Baltimore</b>  |  |   | 13c. CITY OR TOWN<br><b>-</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>7110 GERMAN Hill Rd 21222</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES P. TRAUTWEIN</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NELLIE Elmore</b>   |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>            |  |  |  |
| 16a. SOCIAL SECURITY NO.<br><b>-</b>   |  |   | 17. INFORMANT<br><b>MRS MARIE SMITH</b>   |   |   | ADDRESS<br><b>7110 GERMAN Hill Rd 21222</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Concussion</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>undifferentiated ca of lungs</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>   |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4-6 hrs</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>-</b>  |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1986</b> to <b>2/24/87</b> 19____, that (I) (we) lost saw the deceased alive on <b>2/24/87</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>R. S. MAGNO</b>   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. S. MAGNO</b>  |  |   | 22e. ADDRESS  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  |   | 23b. DATE<br><b>2-28-87</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GLEN HAVEN CEM</b>                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>AA Co. MD</b>     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Kaczorowski Funeral Home 2525 Fleet St. 21224</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 27 1987</b>   |   |   | 25b. REGISTRAR'S SIGNATURE   |  |  |  |

MEDICAL CERTIFICATION

TRANSFERS

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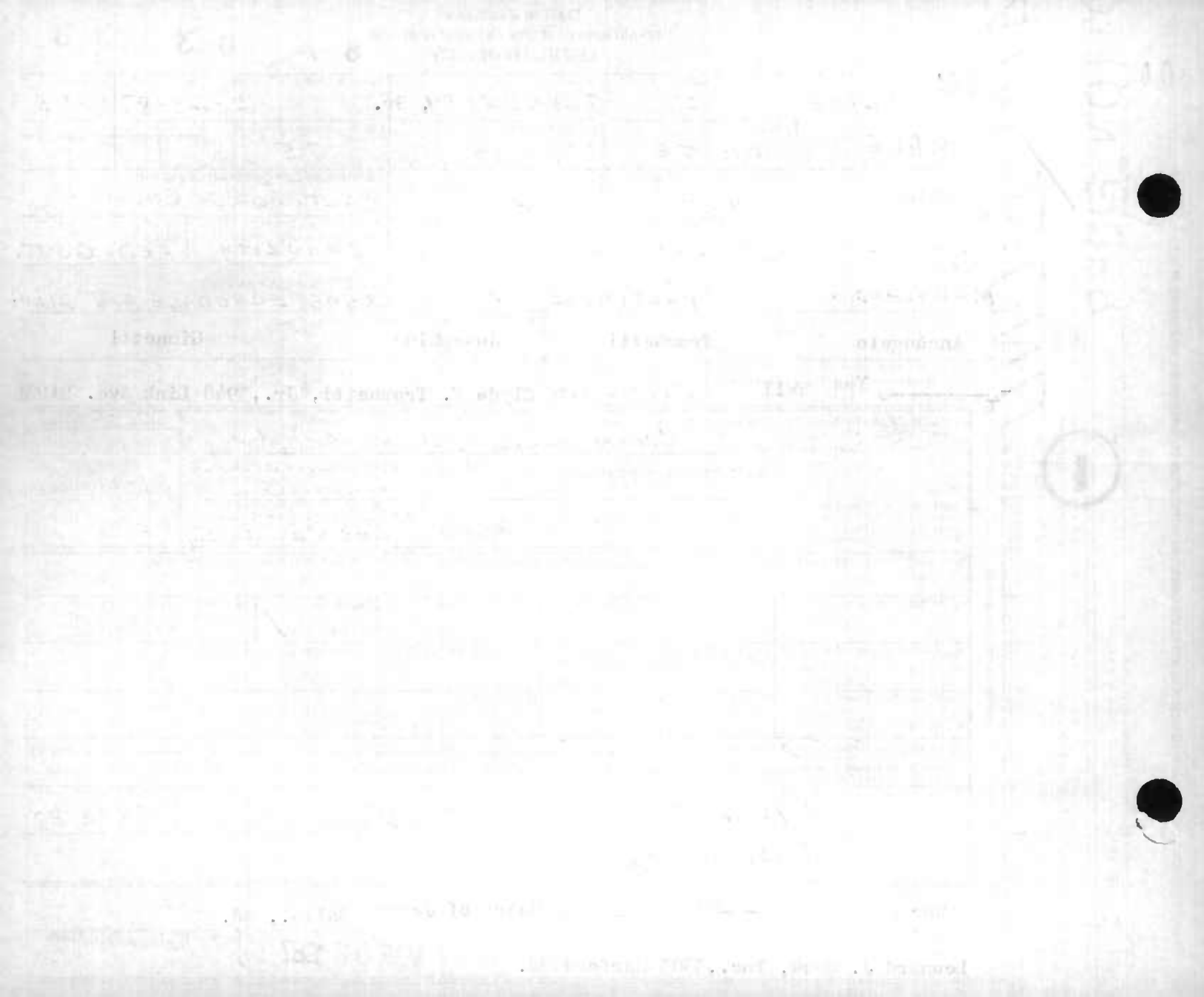
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |  |   |  |                             | 87 03938<br>REG. NO.           |  |
|--|--|--|--|--|---|--|---|--|-----------------------------|--------------------------------|--|
| 1- FOR STATE REGISTRAR   |  |  | 1 DECEASED NAME<br>FIRST MIDDLE LAST<br>CLYDE F. TROMBETTI, Jr.        |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2-28-87   |   |  | 2b. HOUR<br>8:04 PM         |                                |  |
| 3. SEX<br>MALE   |  | 4 RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 17 1911  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |                             | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Ohio  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.   |   |  |                             |                                |  |
| 10 CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SECURITY   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>FED. GOVT.  |                             |                                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |  |  | 13b. CITY OR TOWN<br>BALTIMORE   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br>3505 ECHODALE AVE 21214 |  |                             |                                |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ancangelo Trombetti   |  |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>Josephine Ginnetti          |  |   |  |   |  |                             |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/><br>Yrs. WWII   |  |  | 16b. SOCIAL SECURITY NO.<br>279-10-1588                                |  | 17. INFORMANT ADDRESS<br>Clyde F. Trombetti, Jr., 3940 Link Ave. 21236                          |  |   |  |                             |                                |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiogenic Shock due to</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>acute myocardial</u><br>(b) <u>infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF <u>ASND. Tachycardia</u><br>(c) <u>LAD Cor. artery</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1-2 hours<br>- ? |  |  |  |  |   |  |   |  |                             |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |   |  |   |  |                             |                                |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |   |  |                             |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                             |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |   |  |                             |                                |  |
| 22b. SIGNATURE<br>H. F. Awaranda   |  |  | DEGREE   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>2/28/87 |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. F. Awaranda  |  |  | 22e. ADDRESS   |  |   |  |   |  |                             |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>3-4-87  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Jesus                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md. |  |                             |                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc., 5305 Harford Rd.  |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 02 1987   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Ruck   |                             |                                |  |



BP

DHMH : 16 60M 7/84  
(VRA 15, 4)1- FOR  
STATE  
REGISTRAR

aka Anna E. Utz

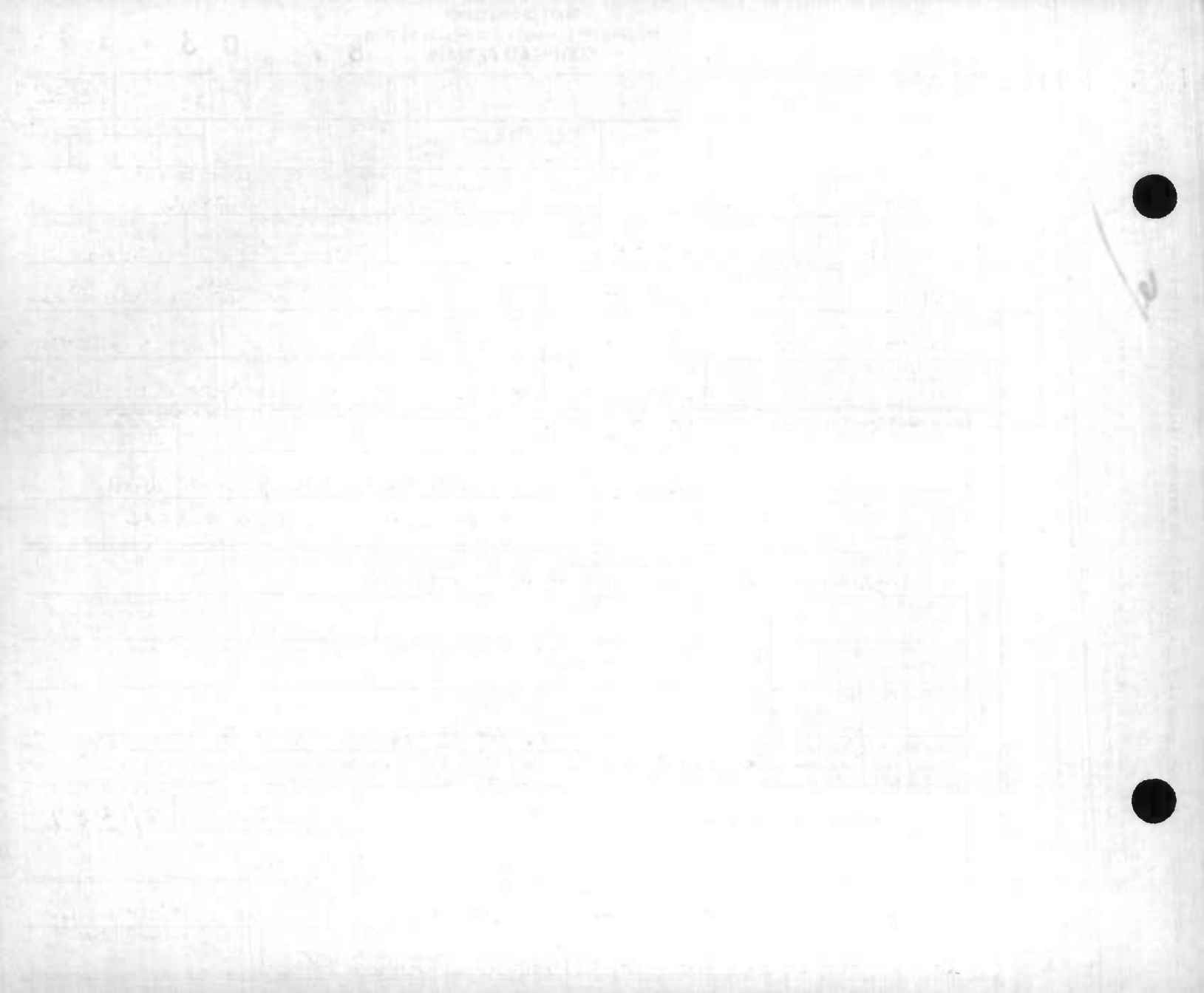
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 03939  
REG. NO.

|  |  |  |  |   |  |   |   |  |   |
|--|--|--|--|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BESSIE E. UTZ   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 12 87                         |   |  | 2b. HOUR<br>11:00A  |   |  |   |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 6 99   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |   |  |   |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridian Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Food Service.               |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>C&P Telephone   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>4919 Cedar Garden Road, 21229  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert T. Creamer  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Anna Peppersack   |  |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-05-1059   |  | 17. INFORMANT ADDRESS<br>Dorothea M. Grines, 4919 Cedar Garden Road   |  |   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PNEUMONIA</u>   |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>RIGHT ACH LEFT CORONARY ARTERIAL ACCIDENT WITH</u>  |  |  |  |   |  |   |   |  |   |
| (c) <u>RIGHT HEMIPARESIS AND PARALYSIS</u>   |  |  |  |   |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HYPERTENSION, CONGESTIVE HEART FAILURE</u>   |  |  |  |   |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |
| 22a. I certify that (u) (this hospital) attended the deceased from <u>12/13</u> 19 <u>79</u> , to <u>DO NOT</u> 19 <u>80</u> , that (u) (we) last saw the deceased alive on <u>2/12/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |  |   |
| 22b. SIGNATURE<br><u>Allen D. Kuhn, MD</u>   |  |  |  |   |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br><u>2/13/87</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Allen Kuhn, II</u>   |  |  |  |   |  | 22e. ADDRESS<br><u>1001 Pine Heights Ave.</u>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>  |  |  | 23b. DATE<br><u>2/16/87</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Moreland Memorial Pk.</u> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Hillendale Baltimore Md.</u> |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</u>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 17 1987</u>   |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. This certificate may also be used for the purpose of filing with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, disease, traumatic event, the medical examiner must be notified or called.

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 87 03940                            |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1 - STATE REGISTRAR   |  | DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Charles William Vestal, Sr.</b>  |  |  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>February 8, 1987</b>   |  | 2b HOUR<br><b>M</b>                          |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>May 21, 1921</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>65</b>  |  | 7 IF UNDER 1 YEAR MONTHS DAYS<br><b>0 0</b>  |  | 8 IF UNDER 24 HRS. HOURS MIN.<br><b>0 0</b>  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Essex 21221</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)<br><b>304 Liberty Rd.</b> |  |  |  | 12a USUAL OCCUPATION<br><b>Service Rep.</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Hospital Equip</b>  |  |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13b STATE 13c CITY OR TOWN<br><b>Maryland Baltimore Essex</b>  |  |  |  |  |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e STREET ADDRESS / ZIP CODE<br><b>304 Liberty Rd. 21221</b>  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Carlton Vestal</b>   |  |  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Carrie Lang</b>  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>WWII</b>   |  | 17 INFORMANT<br><b>Rita M. Vestal, Wife</b>  |  | ADDRESS<br><b>Same</b>   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>probable myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypertension</b>                    |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (it) did not view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b SIGNATURE <b>S. Shilshorn, MD</b> DEGREE  |  |  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><b>2/9/87</b>   |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  | 22e ADDRESS  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b DATE<br><b>2/11/87</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Mary</b>   |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br><b>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave 21221</b>  |  |  |  |  |  | 25a DATE REC'D. BY REGISTRAR   |  | 25b REGISTRAR'S SIGNATURE<br><b>Julia Sanders-Randall</b>  |  |  |  |

BP

RECEIVED  
FEB 11 1967  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

Office: William Westall, Jr.  
February 8, 1967

|                 |                 |              |      |
|-----------------|-----------------|--------------|------|
| Male            | White           | Mar 21, 1921 | 28   |
| North Carolina  | USA             |              |      |
| Arrest 1961     | 30- Liberty St. |              |      |
| Married         | Married         | Arrest 1961  | x    |
| Carlton Westall | Carlton Westall |              |      |
| Yes             | Yes             | 2-6 CV 480   | Same |

Arrested: 2/11/67  
Arrested at: 30 Liberty St., W.D.

100-440000-100  
FEB 09 1967  
FEB 09 1967

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03941  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MALCOLM G. VINZANT                               |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 2, 1987   |   | 2b. HOUR<br>3:45A M   |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 26, 1902   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mississippi                                | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                      |   |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Summit Nursing Home |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Automologist. | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Government            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |   |   |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Catonsville  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>415 J Wheaton Place 21228                       |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert J. Vinzant                             |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary G. Broadfoot                              |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-42-4397  |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Eugenia Vinzant Same as # 13                     |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Pneumonia*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Aspiration*

DUE TO, OR AS A CONSEQUENCE OF

(c) *multistroke cerebral degeneration for yrs*

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
*few weeks*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

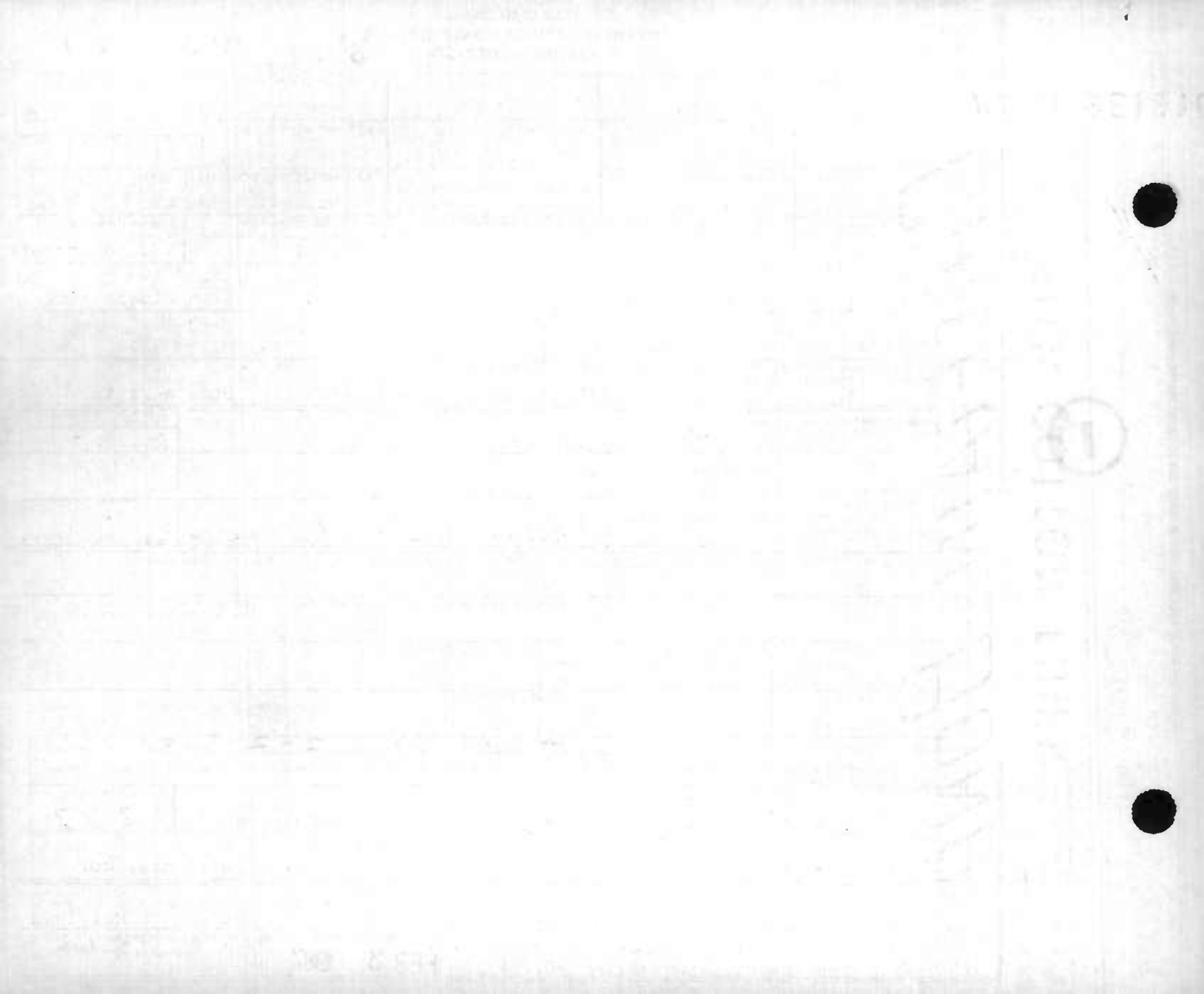
|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/10</i> 19 <i>87</i> , to <i>2-2</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>1/29</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><i>Laurence R. Gallager</i><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED<br><i>2-2-87</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Laurence R. GALLAGER   |  |  |  | 22e. ADDRESS<br>Suite 300<br>3455 Wilkens Avenue, Baltimore, MD.               |   |

|  |                     |   |  |
|--|---------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>2/5/87 | 23c. NAME OF CEMETERY OR CREMATORY<br>Good Shepherd | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Ellicott City Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leo M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, MD. 21228 |                     | 25a. DATE REC'D. BY REGISTRAR<br>FEB 3 1987         | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove all other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BP  
DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove contents of this certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner would be notified by the funeral director. This certificate should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of this certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 87 03942   |  |  |  |
|--|--|--|--|--|--|--|--|
| FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (AKA) Leona Margaret McGee Wagner<br>(TYPE OR PRINT) <b>LEONA M. WAGNER</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2-28-87</b>   |  | 2b. HOUR<br><b>925 A.M.</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>SEPT. 12, 1902</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD. MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON MD.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>STELLA MARIS HOSPICE</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Food Buyer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Foods</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>TOWSON</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Robert John Lee McGee</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Elizabeth Rhinehart</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-01-1627</b>   |  | 17. INFORMANT ADDRESS<br><b>Baltimore, MD. 21206</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ischemic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                    |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-5</b> , 19 <b>82</b> , to <b>2-28</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2-25</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |  |  | 22b. SIGNATURE DEGREE<br><b>Dr. Eddie Nakhuda</b>  |  |  |  |
| 22c. DATE SIGNED<br><b>2-28-87</b>   |  |  |  | 22d. ADDRESS<br><b>Stella Maris, Towson, Md. 21204</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3 Mar 1987</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery, Baltimore City, Maryland</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Martin D. Lawson</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 02 1987</b>  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodgers</b>  |  |  |  |  |  |  |  |

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044317 FEB 78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 7 0 3 9 4 3  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>myka L Warmbold   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 - 9 - 87   |  | 2b. HOUR<br>11:30 M                       |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 15 07   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS                                  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>md.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.               |   |
| 10. CITY OR TOWN OF DEATH<br>Balto   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. Joseph's |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                              |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                |   |   |   |  |   |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Parkville  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>9009 Chateaugay Ct. 21234                |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick G. Creutzer, Sr.                                   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Myra Lee Powell                                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |   | 16b. SOCIAL SECURITY NO.<br>220-46-0080   |   | 17. INFORMATION<br>9009 Chateaugay Ct. 21234<br>Frederick G. Creutzer, Jr. |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Severe COPD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Pneumonia</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br>Natividad D. de Leon, M.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  |  | 22c. DATE SIGNED<br>2/9/87   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NATIVIDAD D. DE LEON, M.D.   |  |  |  | 22e. ADDRESS<br>C/O ST. JOSEPH HOSPITAL, TOWSON, MD. 21204                           |   |

|   |                            |  |   |
|---|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>Feb. 12, 1987 | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge, Howard, Md. |
| 24. FUNERAL DIRECTOR<br>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Balto., Md. 21214 |                            | 25a. DATE REC'D. BY REGISTRAR<br>FEB 13 1987               |   |
|   |                            | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                  |   |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove the box papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's certificate must be filed with this certificate.

[Faint, mostly illegible text covering the main body of the page, possibly a memorandum or report.]

1



045220 FEB 26 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---------------------------------|--|--|--|--|--|--|--|--|--|
| FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | 8 7 0 3 9 4 4  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 1- REGISTRAR   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| LESTER WARREN  |  |  |  |  |  |  |  |  |  | FEBRUARY 23, 1987  |  |  |  |  |  |  |  |  |  | 11:55 A  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 3 SEX  |  |  |  |  |  |  |  |  |  | 4 RACE   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS   |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR IF UNDER 24 HRS |  |  |  |  |  |  |  |  |  |
| MALE   |  |  |  |  |  |  |  |  |  | WHITE  |  |  |  |  |  |  |  |  |  | JULY 21 1918   |  |  |  |  |  |  |  |  |  | 68 YRS  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |  |  |  |  |  |  | MD.                             |  |  |  |  |  |  |  |  |  |
| PENNSYLVANIA   |  |  |  |  |  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | BALTIMORE COUNTY  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| FORT HOWARD  |  |  |  |  |  |  |  |  |  | VA MEDICAL CENTER  |  |  |  |  |  |  |  |  |  | Retired  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 13a. STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. STREET ADDRESS / ZIP CODE  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| MARYLAND   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | BALTIMORE  |  |  |  |  |  |  |  |  |  | 2129 LAKE AVENUE  |  |  |  |  |  |  |  |  |  | 21210                           |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| Herbert Warren   |  |  |  |  |  |  |  |  |  | Ellen Eister   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT ADDRESS  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| YES  |  |  |  |  |  |  |  |  |  | WWII   |  |  |  |  |  |  |  |  |  | 186 01 4811  |  |  |  |  |  |  |  |  |  | CLINICAL RECORDS, VAMC, FORT HOWARD, MD   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  | IMMEDIATE CAUSE (a) CARDIAC ARREST   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  | MINUTES   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | YEARS  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) OLD MYOCARDIAL INFARCT  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | YEARS  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |  |  |  |  | DIABETES MELLITUS, PVD, ST. POST RT. BKA, GANGERENE LEFT FOOT  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  |  |  |  |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 23, 19 87, to FEBRUARY 23, 19 87, that (I) (we) last saw the deceased alive on FEBRUARY 23, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If one) (If one) did not view the body after death. |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| PETER V. JUVAN, M.D.   |  |  |  |  |  |  |  |  |  | VA MEDICAL CENTER, FORT HOWARD, MD 21052   |  |  |  |  |  |  |  |  |  | 2-24-87  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| Burial   |  |  |  |  |  |  |  |  |  | 2/28/87  |  |  |  |  |  |  |  |  |  | Druid Ridge Cem.   |  |  |  |  |  |  |  |  |  | Baltimore Maryland  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  |  |  |  |  |  |  | 25a. ADDRESS   |  |  |  |  |  |  |  |  |  | 25b. DATE SIGNED BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25c. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| A. Alan Seitz, Jr.   |  |  |  |  |  |  |  |  |  | 3818 Roland Ave. 21211   |  |  |  |  |  |  |  |  |  | FEB 25 1987  |  |  |  |  |  |  |  |  |  | Julia Seitz, Jr.  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1947-48 937

040756 JAN 13 1987

#5, G-624, 2/2/87, by F.H., STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03945

1- FOR  
STATE  
REGISTRAR

Gbj.

REG. NO.

|  |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(Last, first, middle, initial)<br><b>Lola H Watkins</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 12 1987</b>  |   | 2b. HOUR<br>MIN.<br><b>9:30 AM</b>  |   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT. 7, 1895</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST Joseph Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. CITY OR TOWN<br><b>21239</b>  |   | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   | 13d. STREET ADDRESS / ZIP CODE<br><b>6401 LOCH RAVEN BLVD. 21239</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES JACOB HARE</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH RHULE</b>  |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-24-5202</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>JOHN B. WATKINS 1827 EDGEWOOD RD. 21234</b>                                    |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-12-87</b> to <b>1-12-87</b> , that (I) (we) last saw the deceased alive on <b>1-12-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Adel S. EL-Hennawy</b>  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Adel S. EL-Hennawy</b>   |  |  | 22e. ADDRESS<br><b>S J H.</b>  |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>JAN. 17, '87</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FORK U.M. CHURCH</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CO., MD</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM E. JOHNSON</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 13 1987</b>  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Benton-Randall</b>                               |  |  |  |



044217 FEB 17 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

03946

1- STATE REGISTRAR UNKNOWN #87-22 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                             |  |  |   |
|---|-----------------------------|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>WAYNE EDWIN WEBB SR</b>  |                             | 20. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTI-MATED <input type="checkbox"/><br>MONTH DAY YEAR<br><b>1/ 31/ 1987</b>           |  | 2b. HOUR<br>M<br><b>11:20</b>   |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>Black</b>     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 5 1953</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>33</b> YRS. | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash. D.C.</b>   |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1203 Valley Brook Court (front)</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Baltimore County, Md.</b>   |
| 13a. STATE<br><b>M.D.</b>   |                             | 13b. COUNTY<br><b>AA</b>   | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Webb</b>  |                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IRENE HARRIS</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(O, OR UNKNOWN)<br><b>NO</b>  |                             | 16b. SOCIAL SECURITY NO.<br><b>217568365</b>   |  | 17. INFORMANT<br><b>218 Gross Avenue, Annapolis, Md.</b><br><b>IRENE MARINE 21401</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple (2) Gunshot Wounds of Head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                             |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                             |  |  |   |
| 19a. DATE OF OPERATION  |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 1/31/ 1987</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>found shot in fire damaged pick-up truck</b>                            |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |                             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>truck</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1203 Valley Brook Ct., Catonsville, Balto., Md.</b>   |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                             |  |  |   |
| ACTUAL SIGNATURE<br><i>[Signature]</i>  |                             | TITLE (SPECIFY)<br><b>Chief</b>  |  | DATE SIGNED<br><b>2/1/87</b>  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John E. Smialek, M.D.</b>   |                             | ADDRESS<br><b>111 Penn St.</b>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   | 23b. DATE<br><b>2/13/87</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balt. Md.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Kene &amp; Son's Annapolis, Md.</b>  |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1987</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

928113 NOTED 3/20/64

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KIRBY  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 3 9 4 7

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LUCY WEE DEN</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-20-87</b>   |  | 2b. HOUR<br><b>3 P M</b>  |  |
| 2. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>NEGRO</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4-24-81</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>105</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balt. County</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GED COURT NURSING HOME</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  |  |
| 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS, ZIP CODE<br><b>2806 LONDON CT 21216</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES L. BALL</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>? ? ?</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |
| 16b. SOCIAL SECURITY NO.<br><b>215-46-9160</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Frank Ball 2806 London Ct</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>EVEN CARDIOVASC</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>DEHYDRATION &amp; MALNUTRITION</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>1986</b> to <b>FEB 20</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>FEB 20</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>Ramon S. Pimentel, Jr.</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>2/22/87</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAMON S. PIMENTEL, JR.</b>  |  | 22e. ADDRESS<br><b>7501 LIBERTY RD, BALTO. MD 21207</b>   |  | 22f. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/25/87</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore County MD</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Locks Funeral Home 1304 N. Central Ave</b>   |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1987</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John B. Davidson</b>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

James Stewart, Jr.

James Stewart, Jr.

James Stewart, Jr.

James Stewart, Jr.

James Stewart, Jr.

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| FOR STATE REGISTRAR  |  |                      |  |   |  |  |  |                            |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |  |  |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                       |  |  |  |  |  |  |  | REG. NO. 03948   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|----------------------|--|---|--|--|--|----------------------------|--|---|--|---|--|--|--|--|--|--|--|--|--|-----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Helen Weibe</b>  |  |                      |  |   |  |  |  |                            |  | 2a. DATE OF DEATH <input checked="" type="checkbox"/> KNOWN <input type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>2 26 1987</b> |  |   |  |  |  |  |  |  |  | 2b. HOUR <b>M</b>  |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>white</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 17 99</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>87 YRS.</b> |  | IF UNDER 1 YR. MONTHS DAYS |  | IF UNDER 24 HRS. HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD <b>2 26 1987</b> |  |  |  |  |  |  |  |  |  | 2d. HOUR <b>3:15P</b> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hungary</b>   |  |                      |  |   |  |  |  |                            |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |   |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                       |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD</b>                             |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Lansdowne</b>   |  |                      |  |   |  |  |  |                            |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4380 Hollins Ferry Road</b>                  |  |   |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Line Worker</b>   |  |                       |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Calvert Distillery</b>                                  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>Maryland</b>   |  |                      |  |   |  |  |  |                            |  | 13b. COUNTY <b>Baltimore</b>  |  |   |  |  |  |  |  |  |  | 13c. CITY OR TOWN <b>Lansdowne</b>   |  |                       |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS <b>4380 Hollins Ferry Rd. 21227</b>           |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Horvath</b>   |  |                      |  |   |  |  |  |                            |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Kertez</b>  |  |   |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>   |  |                       |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>212-12-0822</b>  |  |  |  |  |  |  |  |  |  | 17. INFORMANT ADDRESS <b>Charles Schwarz 10 Palmway Ct. 21013</b> |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Blunt head trauma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                      |  |   |  |  |  |                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |  |  |  |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                           |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |  |   |  |  |  |                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  |   |  |  |  |                            |  | 21b. TIME OF INJURY HOUR <b>XX</b> MONTH DAY YEAR <b>? P.M. 2 26 19 87</b>  |  |   |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject assaulted</b>   |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |                      |  |   |  |  |  |                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>   |  |   |  |  |  |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>4380 Hollins Ferry Rd, Lansdowne, Balto., MD.</b>  |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |  |   |  |  |  |                            |  | TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER  |  |   |  |  |  |  |  |  |  | DATE SIGNED <b>2/27/87</b>   |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <i>William M. Zane</i>  |  |                      |  |   |  |  |  |                            |  | EXAMINER'S NAME (TYPE OR PRINT) <b>William M. Zane, M.D.</b>  |  |   |  |  |  |  |  |  |  | ADDRESS <b>111 Penn St. Balto. MD.</b>   |  |                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  |   |  |  |  |                            |  | 23b. DATE <b>3/2/87</b>   |  |   |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>   |  |                       |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard Maryland</b>                      |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>  |  |                      |  |   |  |  |  |                            |  | ADDRESS <b>4107 Wilkens Ave.</b>  |  |   |  |  |  |  |  |  |  | 25a. DATE REC'D BY REGISTRAR <b>MAR 02 1987</b>  |  |                       |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSMIT WITH PAGES 1 AND 2. SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

NOV 19 1944

RECEIVED



MAR 2 1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove within place. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 18 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 87 03949   |  |
|---|--|---|--|--|--|
| FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 2a DATE OF DEATH MONTH DAY YEAR  |  |
| SAMUEL WEINSTEIN  |  |   |  | FEBRUARY 25, 1987  |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH MONTH DAY YEAR   |  |
| MALE  |  | CAUCASIAN   |  | DEC. 29, 1896  |  |
| 6a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7a CITIZEN OF WHAT COUNTRY?   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  |
| RUSSIA  |  | U.S.A.  |  | 90 YRS   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |
| BALTIMORE   |  | MILFORD MANOR NURSING HOME  |  | BALTIMORE COUNTY MD  |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| GROCER  |  | FOOD  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  |
| MARYLAND  |  |   |  | BALTIMORE  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 13d. STREET ADDRESS / ZIP CODE   |  |
| NATHAN WEINSTEIN  |  | BELLE   |  | 6628 VINCENT LA, APT. 102 (21215)  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17 INFORMANT ADDRESS   |  |
| YES   |  | WWI-ARMY  |  | MRS. BELLA LEVIN 6811 WILLIAMSON AVE. 21215                                    |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Sepsis</u>   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |
| (b) <u>Chronic Aspiration</u>   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |
| (c) <u>Hyperextension of Stroke</u>   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |   |  |  |  |
| <u>Ca prostate, ASHP</u>  |  |   |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?   |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
|   |  | P.M. 19   |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |
|   |  |   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 19 <u>84</u> , to <u>2/23</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/23</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (did) (and not) view the body after death. |  |   |  |  |  |
| 27b SIGNATURE   |  | DEGREE  |  | 27c. DATE SIGNED   |  |
| <u>Paul Schwartz M.D.</u>   |  | M.D.  |  | 2/26/87  |  |
| 27d PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 27e ADDRESS   |  |  |  |
| PAUL Schwartz M.D.  |  | 6804 Park Heights Ave.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| BURIAL  |  | 2/27/87   |  | ARLINGTON CEMETERY   |  |
| 24 FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |
| SOL LEVINSON & BROS., INC.  |  | MAR 05 1987   |  | Julia Bender-Randall   |  |
| 201 REISTERSTOWN RD. BALTO, IN & MD 21215   |  |   |  |  |  |

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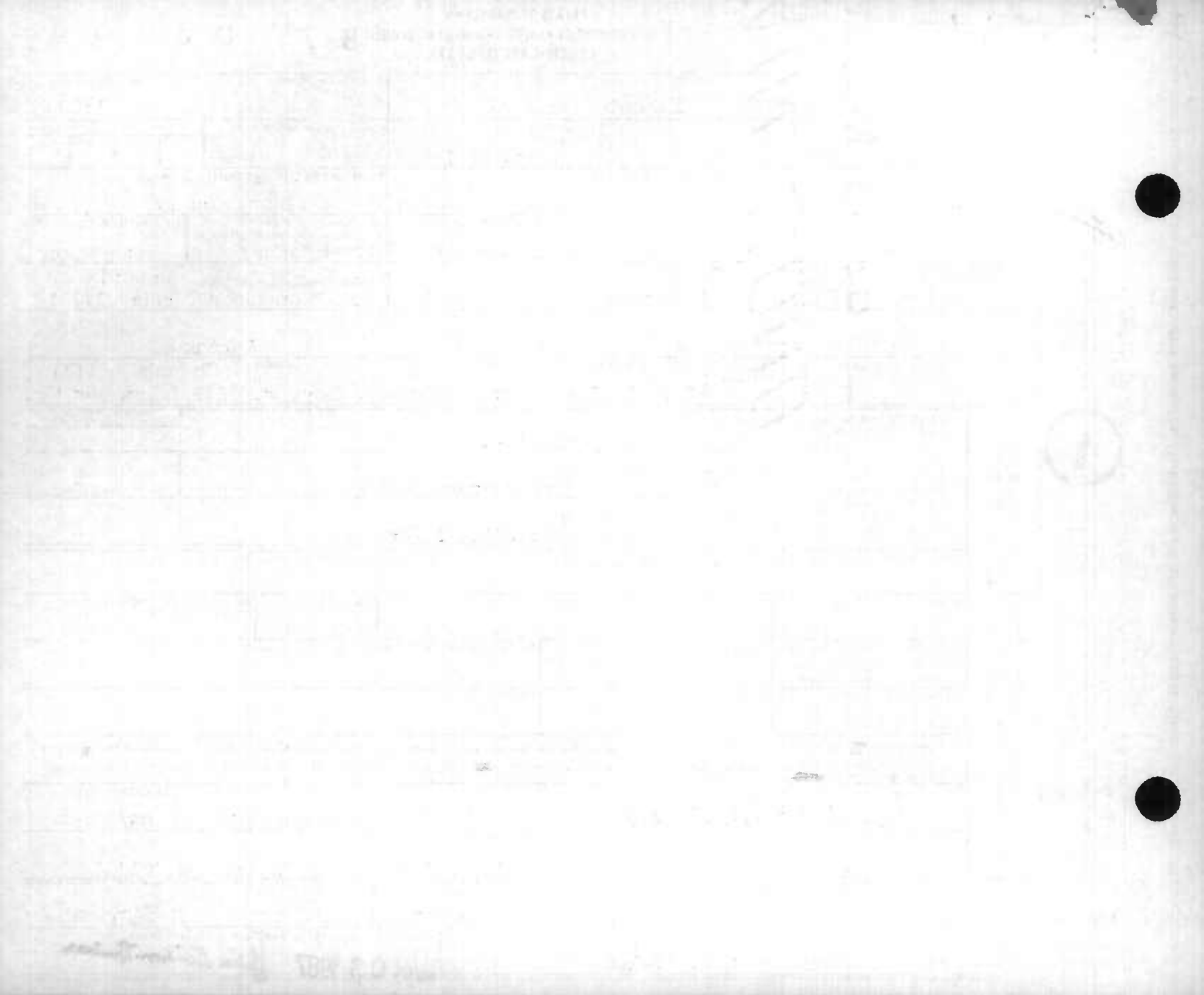
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified orally.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |  | REG. NO. |  |
|--|--|---|--|--|--|---|--|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Kathryn Elizabeth Weitzel</b>   |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02 28 87</b>  |  | 2b. HOUR<br><b>1:00p M</b>  |  |          |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 20 1906</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                              |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Balto. Medical Center</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaker</b>   |  |          |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Phoenix</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>Phoenix 21131</b>  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Cooney</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie Lawrence</b>  |  |   |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>   |  | 17 INFORMANT ADDRESS<br><b>Mrs. Nancy W. Gruver, 3915 Longmoor Cr. Phoenix 21131</b>   |  |   |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemopericardium</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial rupture</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute myocardial infarction</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |   |  |   |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:  |  |   |  |  |  |   |  |   |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |          |  |
| 22a. I certify that (this hospital) attended the deceased from <b>February 24, 19 87</b> , to <b>February 28, 19 87</b> , that (we) lost saw the deceased alive on <b>February 28, 19 87</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.             |  |   |  |  |  |   |  |   |  |          |  |
| 22b. SIGNATURE<br><b>Robert A. Palermo M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br><b>03/01/87</b>   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert A. Palermo, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>6701 N. Charles St. Towson, Md. 21204</b>   |  |   |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/4/87</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |   |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Martin D. Lawson, 10 W. Padonia RD.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 03 1987</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodgers</b>                                     |  |   |  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial or final disposition. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

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REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Mr. John Thomas Welch</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>February 9 1987</b>                                      |  | 2b. HOUR<br>M  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 4 1914</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3527 Cabot Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Chemist</b>         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Food &amp; Drug ADM</b>  |  |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Randallstown</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3527 Cabot Road 21133</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ira Albert Welch</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice Alena Bell</b>  |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b> |  |
| 16a. SOCIAL SECURITY NO.<br><b>172-14-9714</b>  |   | 17. NAME OF DECEASED<br><b>Mr. John T. Welch II</b>   |   | ADDRESS<br><b>21784 6530 MacBeth Way Sykesville Maryland</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>C</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>CONGESTIVE HEART FAILURE; OLD MYOCARDIAL INFARCTION</b>   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-9-81</b> , 19 <b>81</b> , to <b>2/9</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>1-9</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Bernard Rubin</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>2/10/87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARD RUBIN, MD</b>   |   | 22e. ADDRESS<br><b>3502 CROFTON ROAD 21207</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>2/13/87</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crown Crest Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Clearfield Clearfield PA</b>                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers</b>   |   | ADDRESS<br><b>8728 Liberty Road Randallstown, MD. 21133</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1987</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |

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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 1151 | 1152 | 1153 | 1154 | 1155 | 1156 | 1157 | 1158 | 1159 | 1160 | 1161 | 1162 | 1163 | 1164 | 1165 | 1166 | 1167 | 1168 | 1169 | 1170 | 1171 | 1172 | 1173 | 1174 | 1175 | 1176 | 1177 | 1178 | 1179 | 1180 | 1181 | 1182 | 1183 | 1184 | 1185 | 1186 | 1187 | 1188 | 1189 | 1190 | 1191 | 1192 | 1193 | 1194 | 1195 | 1196 | 1197 | 1198 | 1199 | 1200 | 1201 | 1202 | 1203 | 1204 | 1205 | 1206 | 1207 | 1208 | 1209 | 1210 | 1211 | 1212 | 1213 | 1214 | 1215 | 1216 | 1217 | 1218 | 1219 | 1220 | 1221 | 1222 | 1223 | 1224 | 1225 | 1226 | 1227 | 1228 | 1229 | 1230 | 1231 | 1232 | 1233 | 1234 | 1235 | 1236 | 1237 | 1238 | 1239 | 1240 | 1241 | 1242 | 1243 | 1244 | 1245 | 1246 | 1247 | 1248 | 1249 | 1250 | 1251 | 1252 | 1253 | 1254 | 1255 | 1256 | 1257 | 1258 | 1259 | 1260 | 1261 | 1262 | 1263 | 1264 | 1265 | 1266 | 1267 | 1268 | 1269 | 1270 | 1271 | 1272 | 1273 | 1274 | 1275 | 1276 | 1277 | 1278 | 1279 | 1280 | 1281 | 1282 | 1283 | 1284 | 1285 | 1286 | 1287 | 1288 | 1289 | 1290 | 1291 | 1292 | 1293 | 1294 | 1295 | 1296 | 1297 | 1298 | 1299 | 1300 | 1301 | 1302 | 1303 | 1304 | 1305 | 1306 | 1307 | 1308 | 1309 | 1310 | 1311 | 1312 | 1313 | 1314 | 1315 | 1316 | 1317 | 1318 | 1319 | 1320 | 1321 | 1322 | 1323 | 1324 | 1325 | 1326 | 1327 | 1328 | 1329 | 1330 | 1331 | 1332 | 1333 | 1334 | 1335 | 1336 | 1337 | 1338 | 1339 | 1340 | 1341 | 1342 | 1343 | 1344 | 1345 | 1346 | 1347 | 1348 | 1349 | 1350 | 1351 | 1352 | 1353 | 1354 | 1355 | 1356 | 1357 | 1358 | 1359 | 1360 | 1361 | 1362 | 1363 | 1364 | 1365 | 1366 | 1367 | 1368 | 1369 | 1370 | 1371 | 1372 | 1373 | 1374 | 1375 | 1376 | 1377 | 1378 | 1379 | 1380 | 1381 | 1382 | 1383 | 1384 | 1385 | 1386 | 1387 | 1388 | 1389 | 1390 | 1391 | 1392 | 1393 | 1394 | 1395 | 1396 | 1397 | 1398 | 1399 | 1400 | 1401 | 1402 | 1403 | 1404 | 1405 | 1406 | 1407 | 1408 | 1409 | 1410 | 1411 | 1412 | 1413 | 1414 | 1415 | 1416 | 1417 | 1418 | 1419 | 1420 | 1421 | 1422 | 1423 | 1424 | 1425 | 1426 | 1427 | 1428 | 1429 | 1430 | 1431 | 1432 | 1433 | 1434 | 1435 | 1436 | 1437 | 1438 | 1439 | 1440 | 1441 | 1442 | 1443 | 1444 | 1445 | 1446 | 1447 | 1448 | 1449 | 1450 | 1451 | 1452 | 1453 | 1454 | 1455 | 1456 | 1457 | 1458 | 1459 | 1460 | 1461 | 1462 | 1463 | 1464 | 1465 | 1466 | 1467 | 1468 | 1469 | 1470 | 1471 | 1472 | 1473 | 1474 | 1475 | 1476 | 1477 | 1478 | 1479 | 1480 | 1481 | 1482 | 1483 | 1484 | 1485 | 1486 | 1487 | 1488 | 1489 | 1490 | 1491 | 1492 | 1493 | 1494 | 1495 | 149 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-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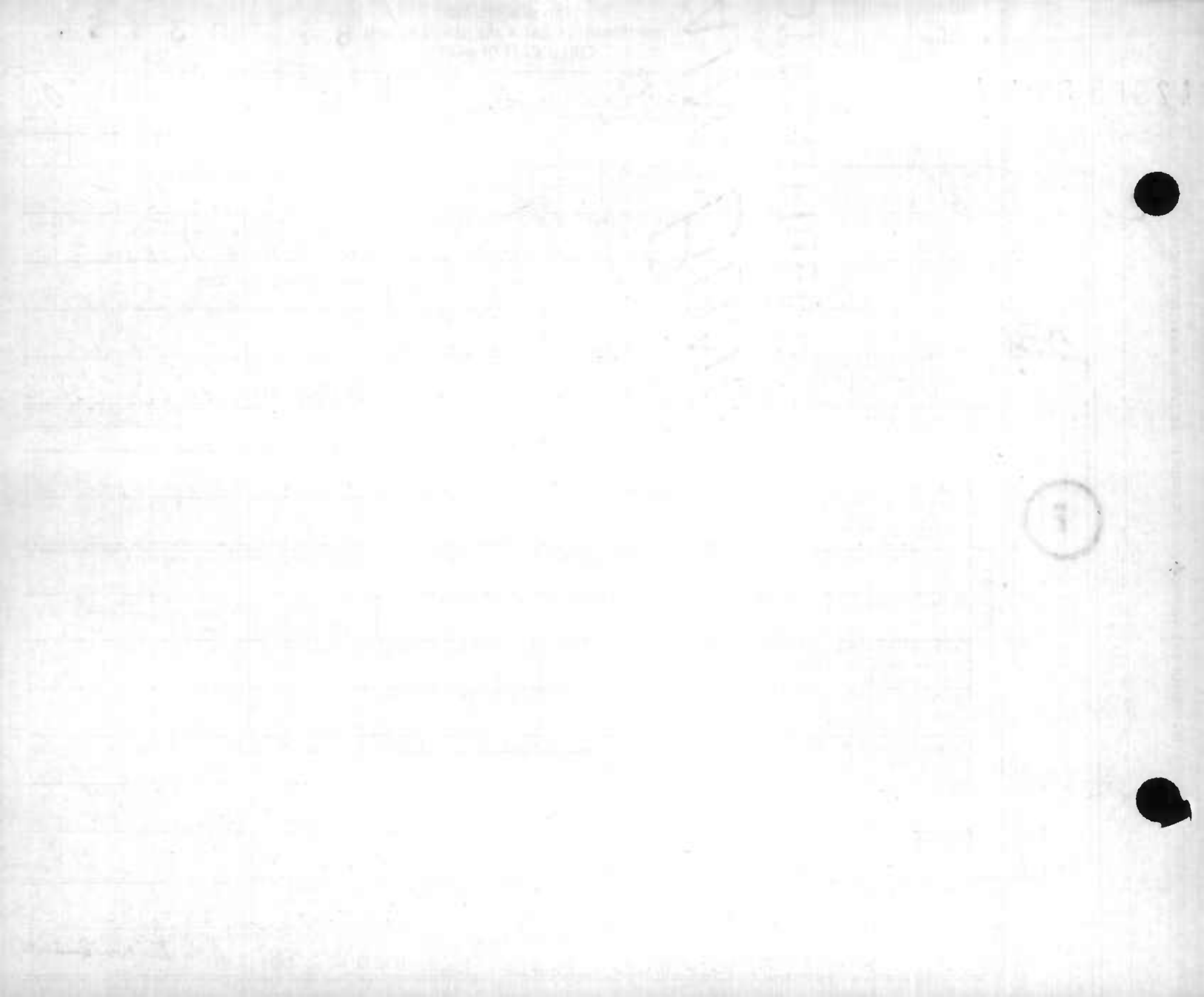


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filled in by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |                       |   |  |   |  |   |   | 8 7 0 3 9 5 2  |  |
|--|--|---|-----------------------|---|--|---|--|---|---|--|--|
| 1- FOR STATE REGISTRAR   |  |   |                       |   | REG. NO.   |   |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Richard Westermeyer  |  |   |                       |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 1 87         |   |  | 2b. HOUR<br>330 PM  |   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |                       | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 13 02  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.  |  |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 2 YRS. HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Saint Joseph Hospital |                       |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Account Assistant              |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Accounting           |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md.  |  | 13b. COUNTY<br>BALTO  |                       | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>8407 C Norfolk Drive 21234              |   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Rudolph D. Westermeyer  |  |   |                       | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Susanna Benner  |  |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>215-01-510  |                       | 17. INFORMANT ADDRESS<br>Richard H. Westermeyer   |  |   |  | 9900 Fox Hill Rd Perry Hall 21234   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiomyopathy Aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Squamous Cell Lung Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 years</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |                       |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>   |  |   |                       |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |   |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |                       | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NO! WHILE AT WORK <input type="checkbox"/>  |  |   |                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>87</u> , to <u>2/1</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/1</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |                       |   |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br>Duane T. S. Soot MD  |  |   |                       |   |  |   |  | 22c. DATE SIGNED<br>2/1/87  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Duane T. S. Soot MD   |  |   |                       |   |  | 22e. ADDRESS<br>7620 York Road Towson Md, 21204   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>2-4-1987 |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>PARKVILLE BALTO MARYLAND       |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>EVANS CHAPLOF MEMORIES  |  |   |                       |   |  | 24b. ADDRESS<br>8800 HARBOR ROAD  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 3 1987                               |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |  |   |  |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Elva R. Wilkie  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 27 1987  |  |   | 2b. HOUR<br>10:30 A M  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 11 1905   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.                                   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                 |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>600 Oak Dean Rd. 21220 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Assembly |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Plastic Mfg.  |   |  |
| 13a. STATE<br>MD  |  |   |  |   | 13b. COUNTY<br>Somerset  |  | 13c. CITY OR TOWN<br>Manokin  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Hiram R. Goghhour   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ola L. McCluhen   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>190-05-5328  |  | 17. INFORMANT<br>ADDRESS<br>Kennard B. Gochnour - same as 13 a b c d e  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/4/88</u> , 19 <u>86</u> , to <u>11/21</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/21</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Adelia A. Mallonga, M.D.</u>   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br>2/27/87  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Adelia Mallonga  |  |   |  |   | 22e. ADDRESS<br>901 Fuselage Ave. Balto. 21220   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>3/2/87  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Beechwood Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Princess Anne - Somerset MD |  |   |  |
| 24. FUNERAL HOME<br>BRADSHAW & SONS CRISFIELD, MD. 21817  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 03 1987   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Lia Davidson-Landell</u>                 |  |   |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>George Leonard Wheeler</b><br><b>GEORGE</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/19/87</b>   |   | 2b. HOUR<br><b>8:58</b>  |  |
| 1. SEX<br><b>MALE</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 19 04</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82 (83)</b>                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co</b> MD.                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital INC.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Plumber</b>              |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Marroll</b>  | 13c. CITY OR TOWN<br><b>Westminster</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>145 A Bond Street 21157</b> |
| 14. FATHER'S NAME<br><b>John F. Wheeler</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Elva L. Frank O'Connell</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-09-4807</b>  |   | 17. INFORMANT ADDRESS<br><b>Elva L. Frank 503 S. Bouldin St. 21224</b>         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial ischemia &amp; CHF</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Mitral Regurgitation AscVD</b>              |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><b>Prostatic Carcinoma with metastasis, Arteriosclerosis, emphysema</b>   |  |   |   |  |  |
| 9a. DATE OF OPERATION   |  | 19a. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Kamal M. M.D.</b>  |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>2/19/87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-24-87</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Overlea, Balto., Co., Md.</b>  |  | 24. FUNERAL DIRECTOR<br><b>Charles S. Zeiler &amp; Son Inc.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 25 1987</b>                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia S. Zeiler-Rand</b>   |  |   |   |  |  |

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Handwritten notes in the middle section, including the word "Faint" and other illegible text.

Handwritten notes at the bottom of the page, including the word "Faint" and other illegible text.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 3 9 5 5

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |                                   |
|--|--|---|--|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>EARL S WHITE      |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 13 87                                      |   | 2b. HOUR<br>9:45 P.M.             |
| 3. SEX<br>Male   | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-12-99  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                                   |
| 7a. BIRTHPLACE, (STATE OR FOREIGN COUNTRY)<br>USA - MD                     | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                      |   |                                   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore, MD                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TRUCK DRIVER |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Cockeysville  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Louis WHITE                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louisa SMITH   |  |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215123746  |  | 17. INFORMANT<br>ADDRESS<br>FAMILY RECORDS  |                                   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Severe Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(b)

uncontrolled DIABETES

DUE TO, OR AS A CONSEQUENCE OF

(c)

Dehydration

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost<br>saw the deceased alive on above, (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |  |   |
| 22b. SIGNATURE<br>ADEL S. EL-HENNAWY MD   | 22c. DATE SIGNED   |  | 22d. ADDRESS<br>S JH.   |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ADEL S. EL-HENNAWY   |  | 22f. ADDRESS<br>S JH.  |   |

|  |                        |  |  |
|--|------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL | 23b. DATE<br>2-17-1987 | 23c. NAME OF CEMETERY OR CREMATORY<br>Union CHAPEL | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Monkton BALTO MARYLAND |
| 24. FUNERAL DIRECTOR<br>NAME<br>EVANS CHAPEL OF CHIMES |                        | 25a. DATE REC'D. BY REGISTRAR                      | 25b. REGISTRAR'S SIGNATURE   |

FEB 18 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

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 78 FEB 25-87  
 FOR  
 STATE  
 REGISTRAR

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03956  
 REG. NO.

|  |                         |  |   |   |  |   |  |   |  |
|--|-------------------------|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MILBURN Edwin WIDERMANN</b>              |                         |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>2 22 19 87</b>  |  |   |  | 2b. HOUR<br>M<br><b>12:56 PM</b>                        |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11-9-1919</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>2 22 19 87</b>   |  | 2d. HOUR<br>M<br><b>12:56 PM</b>                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                       |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hebbville</b>                                      |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3022 N. Rolling Rd.</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired-Operating Engineer</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Hebbville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  | 13e. STREET ADDRESS<br><b>3022 N. Rolling Rd. 21207</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robin Milburn Widerman</b>            |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katie May Hidey</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b> |                         |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-10-6144</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Baltimore MD 21207 Rd.</b><br><b>Mrs. Jeanette M. Widerman 3022 N. Rolling</b> |  |   |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple (2) gunshot wounds to head (handgun)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

|  |  |  |  |   |
|--|--|--|--|---|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 2-22- 19 87</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Self-inflicted.</b> |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3022 N. Rolling Rd., Hebbville, Balto., MD</b>  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |
| ACTUAL SIGNATURE<br><i>Charles P. Kokes</i>  |  | TITLE (SPECIFY)<br><b>Assistant</b> MEDICAL EXAMINER                         |  |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Charles P. Kokes, M.D.</b>  |  | DATE SIGNED<br><b>2-23-87</b>  |  |   |
| ADDRESS<br><b>111 Penn St., Balto., MD 21201</b>   |  |  |  |   |

|  |                             |  |  |
|--|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                 | 23b. DATE<br><b>2-26-87</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Park</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eldersburg Carroll MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc</b> |                             | 25a. DATE RECD. BY REGISTRAR<br><b>FEB 23 1987</b>                   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Donderson-Randall</i>               |
| ADDRESS<br><b>8728 Liberty Rd. Randallstown, MD 21133</b>                  |                             |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

RESEARCH AND ANALYTICAL CHEMISTRY  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

1

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |                         |   |   |   |  |  |  |
|--|-------------------------|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EVE R. WIEDEFELD</b> |                         |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 7 1987</b> |   |  | 2b. HOUR<br><b>3:30 A.M.</b>   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 25 1914</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. Co.</b> MD.                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                     |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>205 E. Joppa Rd., The Ridgely</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  |

|  |  |  |  |  |                                    |  |   |  |  |  |  |
|--|--|--|--|--|------------------------------------|--|---|--|--|--|--|
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>205 E. Joppa Rd., Towson, Md. 21204</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank S. Kocher</b>             |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva R. Dotterman</b> |  |                                    | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |   |  | 16b. SOCIAL SECURITY NO.<br><b>213-05-3556</b>                               |  |  |
| 17. INFORMANT<br>ADDRESS<br><b>Leslie A. Sauter, 412 Overbrook Rd. 21212</b> |  |  |  |  |                                    |  |   |  |  |  |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the lung</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b> |  |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **0**

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>8/19/86</b> , to <b>2/7/87</b> , that (1) (we) lost saw the deceased alive on <b>2/5/87</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Richard J. Gross</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/9/87</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD J GROSS MD</b>   |  |  |  | 22e. ADDRESS<br><b>50 Scott Adams Rd., #201, Catonsville, MD 21030</b>   |  |  |  |

|  |  |                             |  |   |  |   |  |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b> |  | 23b. DATE<br><b>2/10/87</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Balto. Md.</b> |  |
|--|--|-----------------------------|--|---|--|---|--|

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. 21212</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 11 1987</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Benson-Rutten</b> |  |
|--|--|---|--|--|--|

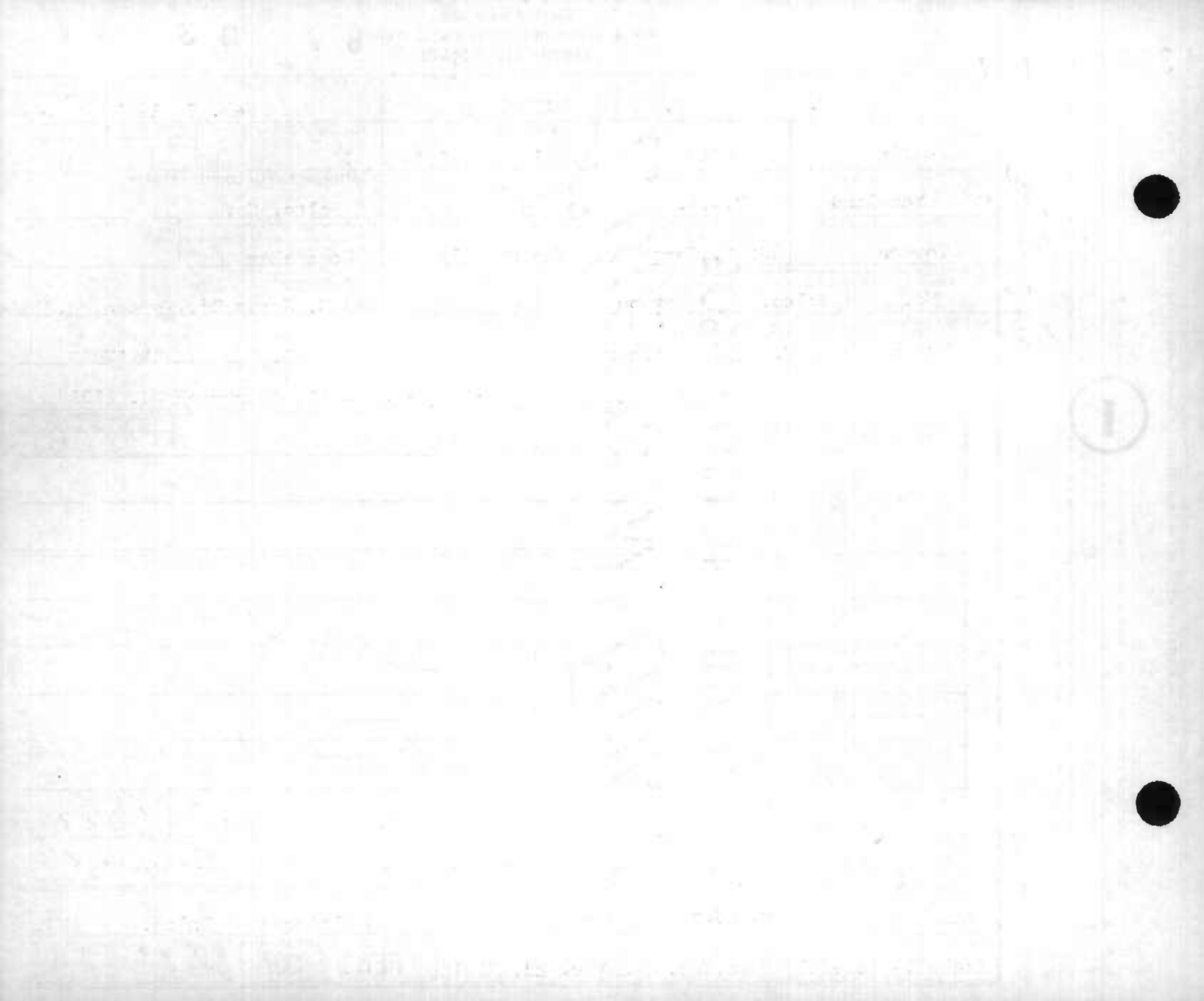
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon pages 4 and 5 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

BP



044747 FEB 20 1987

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03958  
REG. NO.

|  |                         |  |   |  |   |  |  |  |
|--|-------------------------|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES- Wayne WIGGINS, Sr.</b>  |                         |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>2 16 1987</b> |  |   | 2d. HOUR<br><b>12<sup>45</sup> PM</b>  |  |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 8 43</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>44</b> YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>                                  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>2 16 1987</b>                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.              |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore Co. Gen. Hosp</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Disabled</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Soc. Sec Admin</b> |
| 13a. STATE<br><b>MD</b>  |                         | 13b. COUNTY<br><b>Balto</b>  | 13c. CITY OR TOWN<br><b>Woodlawn</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br><b>10 A CEDAR Heights Ct. 21207</b>                    |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jacob Wiggins</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Leggett</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>  |                         | (IF YES, GIVE WAR OR DATES)<br><b>Vietnam</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>238-56-7863</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Iris McFadden 1008 Argonne Dr</b>                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SARCOIDOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                         |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>E. P. Williamson II</b>   |                         |  | TITLE (SPECIFY)<br><b>M.D. Deputy</b>   |  |   | DATE SIGNED<br><b>2/16/87</b>  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>E. P. Williamson II</b>   |                         |  | ADDRESS<br><b>5350 BAYVIEW AVE. NAT'L PK 21228</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         |  | 23b. DATE<br><b>2/21/87</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Vet.</b>             |  | 23d. LOCATION<br>CITY COUNTY STATE<br><b>Owings Mills, Md.</b>           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H West 4300 Wabash Ave.</b>  |                         |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 19 1987</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia F. Wilson-Randall</b>                     |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AT THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

NOTICE



FEB 19 1987

046081 MAR 5 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03959

REG. NO.

|   |  |  |  |                                   |  |
|---|--|--|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR                          |  |
| DECEASED NAME (TYPE OR PRINT)   |  | MONTH DAY YEAR   |  | HOURS MIN.                        |  |
| FIRST MIDDLE LAST   |  | February 27, 1987  |  | 4:40 PM                           |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)  | IF UNDER 1 YEAR                   |  |
| Male  | White  | MONTH DAY YEAR   | 61 YRS.  | IF UNDER 24 HRS.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   |  |
| North Carolina  | USA  |  | Baltimore County MD.   |                                   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore   | 7225 Gough Street  | Port Manager   |  |                                   |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS               |  |
| Md.   | Balto.   | Eastwood   |  | 7225 Gough Street 21224           |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |                                   |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  |                                   |  |
| Julius James Wiggins  |  | Nettie F. Huffman  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS  |  |                                   |  |
| Yes   | WWII   | 240-30-0279 Rosa Marie Wiggins 7225 Gough Street   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA - RT. MAXILLARY SINUS</u>  |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u> |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>POLYCYSTIC KIDNEYS - Post MYOCARDIAL INFARCTION</u>                 |  |  |  |                                   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                               |                                   |  |
| 9/26/86   | CA. OF SINUS   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                                   |  |
|   | P.M. 19  |  |  |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |                                   |  |
|   |  |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/85</u> , 19____, to <u>2/24/87</u> , 19____, that (I) (we) lost   |  |  |  |                                   |  |
| saw the deceased alive on <u>2/24/87</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) see the body after death.) |  |  |  |                                   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED                  |  |
| <u>Max Baum</u>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | <u>3/2/87</u>                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |                                   |  |
| Dr. Max Baum  |  | 7422 Eastern Ave.  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN COUNTY STATE  |                                   |  |
| Burial  | 3/3/87   | Oak Lawn Cemetery  | Baltimore Maryland   |                                   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 25a. DATE DECEASED BY REG. NO.   |  | 25b. REGISTRAR                    |  |
| Connelly Funeral Home 300 Mace Ave. 21221   |  | MAR 04 1987  |  | <u>[Signature]</u>                |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before the body is released for burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

Handwritten notes and calculations, including a table with columns for 'Date', 'Description', and 'Amount'. The text is mostly illegible due to fading.

Handwritten notes and calculations, including a table with columns for 'Date', 'Description', and 'Amount'. The text is mostly illegible due to fading.



Handwritten notes and calculations, including a table with columns for 'Date', 'Description', and 'Amount'. The text is mostly illegible due to fading.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03960

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Georgia Mae Wilhelm</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2-14-87</b>  |   | 2b. HOUR<br><b>6:50 P.M.</b>  |  |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 7 1916</b>   |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>70</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Bethesda Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machine Operator</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Black &amp; Decker</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Maryland</b> |  | 13c. CITY OR TOWN<br><b>Westminster</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Spencer C. Krebs</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Georgia Rice</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-09-2291A</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Patricia Turfle 704 Hughes Shop Rd. Westminster, Md. 21157</b> |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

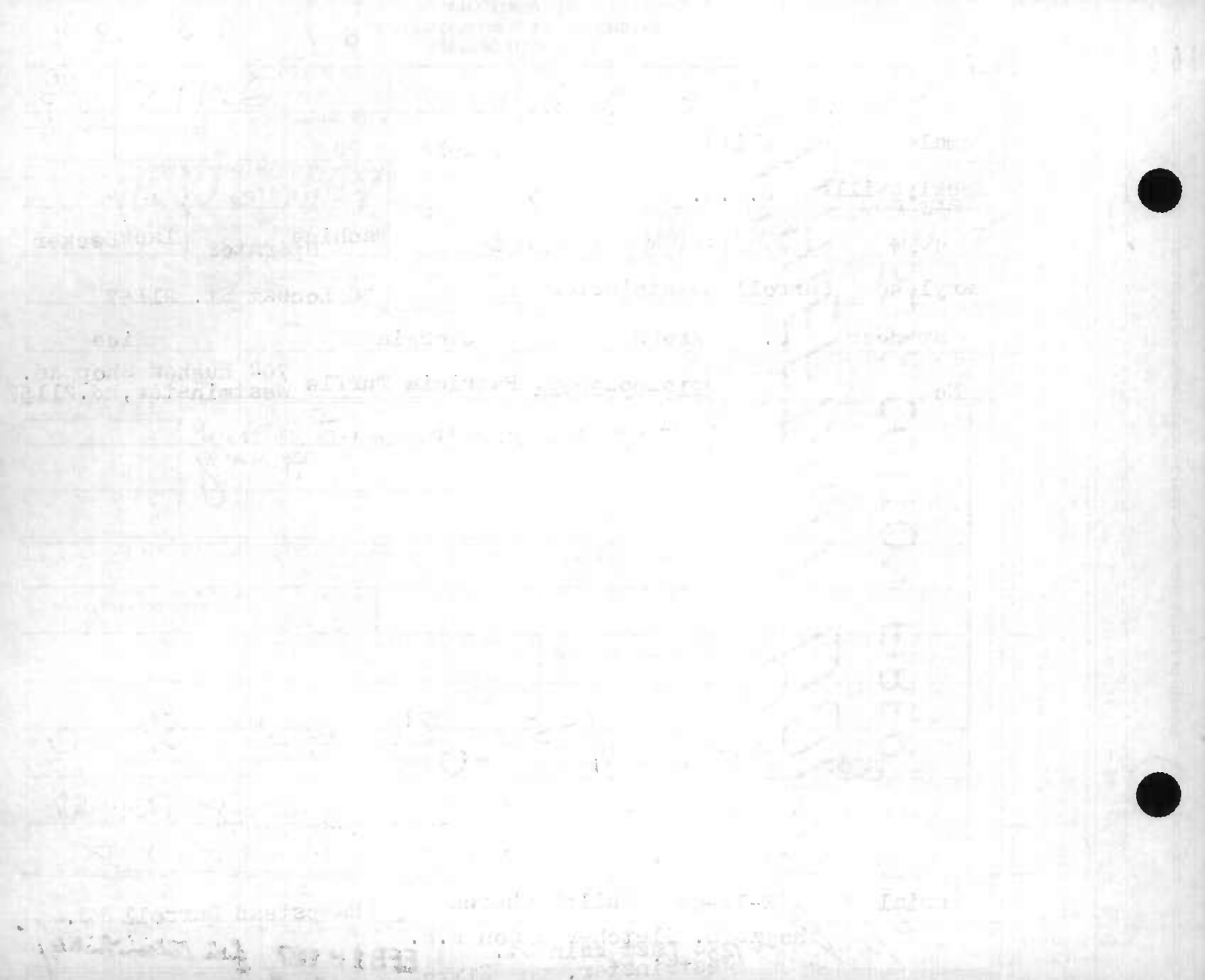
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-5 1987</b> to <b>2-14 1987</b> , that (I) (we) last saw the deceased alive on <b>2-14 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Carla S. Alexander, MD</b>   | DEGREE<br><b>MD</b>  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>2-14-87</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carla S. Alexander, M.D.</b>  |  | 22e. ADDRESS<br><b>Stella Maris Hospice<br/>Dulaney Valley Rd. - Towson, MD 21204</b>  |  |

|  |                             |   |  |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>            | 23b. DATE<br><b>2-17-87</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Shiloh Church</b>                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hampstead Carroll Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Thomas D. Fletcher &amp; Son F.H.</b> |                             | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>EEB 18 1987</b> |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 03961

FOR  
STATE  
REGISTRAR

|  |         |  |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
|--|---------|--|--|--|--|---|--|---------------------------------------|--|--------------------------|--|-------|--|------|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN OF DEATH               |  | MONTH                    |  | DAY   |  | YEAR |  | 2b. HOUR       |  |
| John   |         | P.   |  |  |  | Wilkinson   |  | <input checked="" type="checkbox"/> 2 |  | 12                       |  | 19    |  | 87   |  | M              |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | 7. IF UNDER 1 YR.   |  | 8. IF UNDER 24 HRS.                   |  | 2c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR           |  |
| Male   | White   | 2 15 41  |  | 45 YRS.  |  | MONTHS  |  | DAYS                                  |  | 2 12 1987                |  | 2     |  | 12   |  | 1987           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                       |  |                          |  |       |  |      |  |                |  |
| Pittsburgh, Pa.  |         | USA  |  |  |  | Baltimore City, Co.   |  |                                       |  |                          |  |       |  |      |  | MD             |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                       |  |                          |  |       |  |      |  |                |  |
| Essex  |         | Franklin Square Hospital   |  | Security Guard   |  | Hospital  |  |                                       |  |                          |  |       |  |      |  |                |  |
| 13a. STATE   |         | 13b. CITY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                   |  |                          |  |       |  |      |  |                |  |
| Maryland   |         | Baltimore  |  | Baltimore  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 26 Warren Rd.                         |  |                          |  |       |  |      |  | 21030          |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| John   |         | Lois   |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| No   |         | 165-34-8622  |  | Mrs. Lois Wilkinson  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
|  |         | unknown  |  | Bedford, Pa. 15522   |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| PART I DEATH WAS CAUSED BY:  |         |  |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| IMMEDIATE CAUSE (a)  |         | Salicylate intoxication  |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                  |         | (b)  |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| (c)  |         |  |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 |         |  |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| Alcoholism   |         |  |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?   |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
|  |         |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| 21a. EXTERNAL CAUSE WAS  |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                         |         | ? 2 12 1987  |  | Subject ingested salicylate  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| 21d. INJURY OCCURRED   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |         | home   |  | 1522 Barkley Ave,  |  |   |  |                                       |  |                          |  |       |  |      |  | Baltimore, MD. |  |
| 22a. I certify that I took charge of the remains described above, held on  |         | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| death resulted from  |         | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)  |  | DATE SIGNED  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| William M. Zane, M.D.  |         | M.D. Assistant   |  | 2/13/87  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS  |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| William M. Zane, M.D.  |         | 111 Penn St. Balto. MD.,   |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (CITY OR TOWN)  |  | COUNTY                                |  | STATE                    |  |       |  |      |  |                |  |
| Cremation  |         | 2-14-87  |  | Country Side Crematory   |  | Davidsville Somerset  |  |                                       |  | Pa.                      |  |       |  |      |  |                |  |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| Timothy A. Berkebile   |         | FEB 19 1987  |  | Julia A. Berkebile   |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| NAME   |         | ADDRESS  |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |
| Timothy A. Berkebile   |         | 214 S. Juliana St.   |  |  |  |   |  |                                       |  |                          |  |       |  |      |  |                |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FORWARDED TO THE REGISTRAR WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

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DHMH - 17  
(VR A15 ME (5))

AT KNOXVILLE, TENNESSEE  
JANUARY 10, 1902

Received of \_\_\_\_\_  
the sum of \_\_\_\_\_

PAID  
TO THE ORDER OF  
JAN 10 1902

NO. 1001202

W. H. HARRIS  
TREASURER

1001202

1001202

1001202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 4 should be filed with the health officer after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03962

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |   |  |   |  |  |
|--|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SHIRLEY J. WILKINSON</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEBRUARY 17, 1987</b>           |   |   | 2b. HOUR<br><b>4 P.</b>  |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DEC-23, 1935</b>   |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>51</b> YRS.                                |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROSSDALE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AT HOME</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>ESSEX</b>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>2 FERNSEY COURT 20 21237</b>                  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HUBERT JONES</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EDITH MASON</b>   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-32-5587</b>  |   | 17. INFORMANT ADDRESS<br><b>FAMILY RECORDS</b>                                     |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes Mellitus</b>  |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>1987</b> , to <b>2-17</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2-17</b> , 19 <b>87</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                       |  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>DR. WYMAN K. WONG</b>   |  |  |  |   | 22c. DATE SIGNED<br><b>FEB. 19, 1987</b>  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. WYMAN K. WONG</b>  |  |  |  |   | 22e. ADDRESS<br><b>6801 BELAIR ROAD</b>   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>2-20-1987</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORELAND PARK</b>                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTO. MO.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS CHAPEL OF MEMORIES HARFORD</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 26 1987</b>   |  |   |  |  |
| 25b. REGISTRAR'S SIGNATURE   |  |  |  |   |   |  |   |  |  |

BP

RECEIVED  
FEB 10 1901

101 FEB 10 1901

*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]*

RECEIVED  
FEB 10 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified.

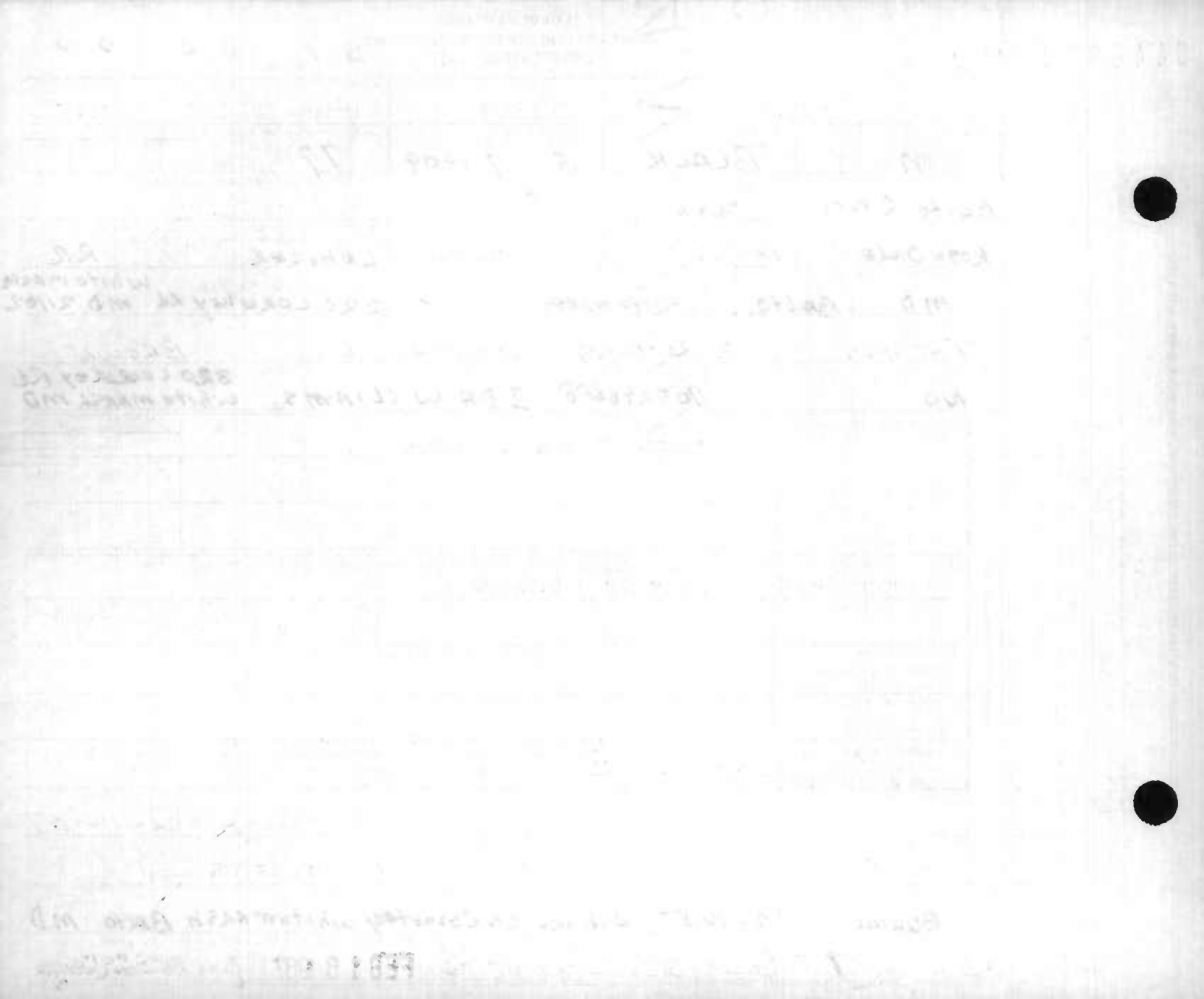
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03963

REG. NO.

|  |  |   |  |  |                     |  |
|--|--|---|--|--|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Arvell Edward WILLIAMS   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 11, 1987 |  | 2b. HOUR<br>6:12P M |  |
| 3. SEX<br>M  |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 7 1909   |                     |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.   |  | 7. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  | 8. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                     |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto Cnty  |  | 9b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     |  |
| 10. CITY OR TOWN OF DEATH<br>ROSEDALE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SOURCE HOSPITAL   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LABORER  |                     |  |
| 13a. STATE<br>MD   |  | 13b. CITY OR TOWN<br>BALTO  |  | 13c. STREET ADDRESS / ZIP CODE<br>320 LORELEY RD MD 21162  |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>THOMAS WILLIAMS  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARIA U BROWN  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |                     |  |
| 16b. SOCIAL SECURITY NO.<br>705 096888   |  | 17. INFORMANT<br>IDA WILLIAMS   |  | 18. ADDRESS<br>320 LORELEY RD WHITE MARSH MD   |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic prostatic cancer<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>Hypercalcemia / Dehydration / Cachexia   |  |   |  |  |                     |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                     |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                     |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                     |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (X) (this hospital) attended the deceased from January 25, 19 87, to February 11, 19 87, that (X) (we) lost saw the deceased alive on February 11, 19 87, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Hany Elnahal, MD   |                     |  |
| 22c. DATE SIGNED<br>2-11-87  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Hany Elnahal, MD   |  | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>2-14-87  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ASBURY CH CEMETARY   |                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>WHITEMARSH BALTO MD  |  | 24. FUNERAL DIRECTOR<br>NAME<br>George Little   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 18 1987   |                     |  |
| 25b. REGISTRAR'S SIGNATURE<br>Julia...   |  | 25c. REGISTRAR'S NAME<br>Julia...   |  | 25d. REGISTRAR'S ADDRESS<br>3836 Old Federal Rd  |                     |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permits. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |                  | 87 03964<br>REG. NO.  |  |
|---|--|---|--|---|--|---|--|--|------------------|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |                  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>MARY D. Williams</u>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH <u>2</u> DAY <u>11</u> YEAR <u>87</u>                                |  | 2b. HOUR <u>3:35</u> AM <u>A</u>   |                  |   |  |
| 3. SEX<br><u>Female</u>   |  | 4. RACE<br><u>White</u>   |  | 5. DATE OF BIRTH<br>MONTH <u>1</u> DAY <u>28</u> YEAR <u>08</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>79</u> YRS  |  | IF UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u>            |                  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><u>PENNSYLVANIA</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE COUNTY, MD.</u>                            |  |  |                  |   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Towson</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>St. Joseph Hospital</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>CHILD CARE WORKER</u>    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>CHILD CARE</u>                               |                  |   |  |
| 13a. STATE<br><u>MARYLAND</u>   |  | 13b. COUNTY<br><u>BALTIMORE</u>   |  | 13c. CITY OR TOWN<br><u>21204</u>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><u>1660 MUSSULA RD. 21204</u>                      |                  |   |  |
| 14. FATHER'S NAME<br>FIRST <u>THOMAS</u> MIDDLE <u></u> LAST <u>DAVIDSON</u>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>MARY</u> MIDDLE <u></u> LAST <u>BRENNEN</u>  |  |   |  |  |                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>181-03-7171</u>  |  | 17. INFORMANT<br>ADDRESS<br><u>SHIRLEY W. PERRY 1660 MUSSULA RD. 21204</u>  |  |   |  |  |                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PROBABLE CEREBRAL VASCULAR ACCIDENT</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>   |  |   |  |   |  |   |  |  |                  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u></u>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>OBACOPURULENT TRACHEOBRONCHITIS</u> <u>MYELOPROLIFERATIVE DISEASE</u>  |  |   |  |   |  |   |  |  |                  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)                  |  |  |                  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>2-9</u> , 19 <u>87</u> , to <u>2-11</u> , 19 <u>87</u> , that (we) lost<br>saw the deceased alive on <u>2-11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (do) (do not) view the body after death. |  |   |  |   |  |   |  |  |                  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  |   |  |   |  | DEGREE  |  |  | 22c. DATE SIGNED |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>REYNALDO ORTUELA-GOMEZ, M.D.</u>  |  |   |  |   |  | 22e. ADDRESS<br><u>7620-YORK ROAD TOWSON MD 21204</u>   |  |  |                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><u>BURIAL</u>  |  |   |  | 23b. DATE<br><u>FEB. 13, '87</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>DULANEY VALLEY MEM. GAR. BALTIMORE CO., MD</u>         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |                  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>WILLIAM E. JOHNSON</u>   |  |   |  |   |  | ADDRESS<br><u>8521 LOCH RAVEN BLVD.</u>   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 13 1987</u>                                  |                  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

Handwritten notes at the top of the page, including the date "April 1934" and various illegible scribbles.

Main body of handwritten text, appearing as several paragraphs of cursive script, mostly illegible due to fading.

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045103 FEB 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 03965  
REG. NO.

|   |                                     |  |   |  |   |
|---|-------------------------------------|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Barbara E Winder  |                                     |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 21-87   |  | 2b. HOUR<br>P M   |
| 3. SEX<br>Female  | 4. RACE<br>White                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 10 1906   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS                                      |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Md  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |
| 10. CITY OR TOWN OF DEATH<br>Towson   |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Multi Medical |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----  |
| 13a. STATE<br>Md.   |                                     |  | 13b. COUNTY<br>Balto.   | 13c. CITY OR TOWN<br>Towson  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Wolff   |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine Graf  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>--- --- ---   |   | 17. INFORMANT<br>ADDRESS<br>G.P. Winder 8013 York Road 21204                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CVA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>AS CVA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                     |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 days</u><br><u>8 days</u><br><u>6+ yrs</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.  |                                     |  |   |  |   |
| 19a. DATE OF OPERATION  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>16 July 1948</u> to <u>21 February 1987</u> , that (I) (we) last saw the deceased alive on <u>21 February 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |                                     |  |   |  |   |
| 22b. SIGNATURE<br><u>Charles F. O'Donnell</u><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |                                     |  |   | 22c. DATE SIGNED<br><u>2/22/87</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles F. O'Donnell   |                                     | 22e. ADDRESS<br>7501 York Road 21204   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |                                     | 23b. DATE<br>2-24-87   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley                           |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lutherville Baltimore Maryland  |                                     | 23e. DATE REC'D. BY REGISTRAR<br>FFR 25 1027   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home 6500 York Road 21212  |                                     | 25. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>   |   |  |   |

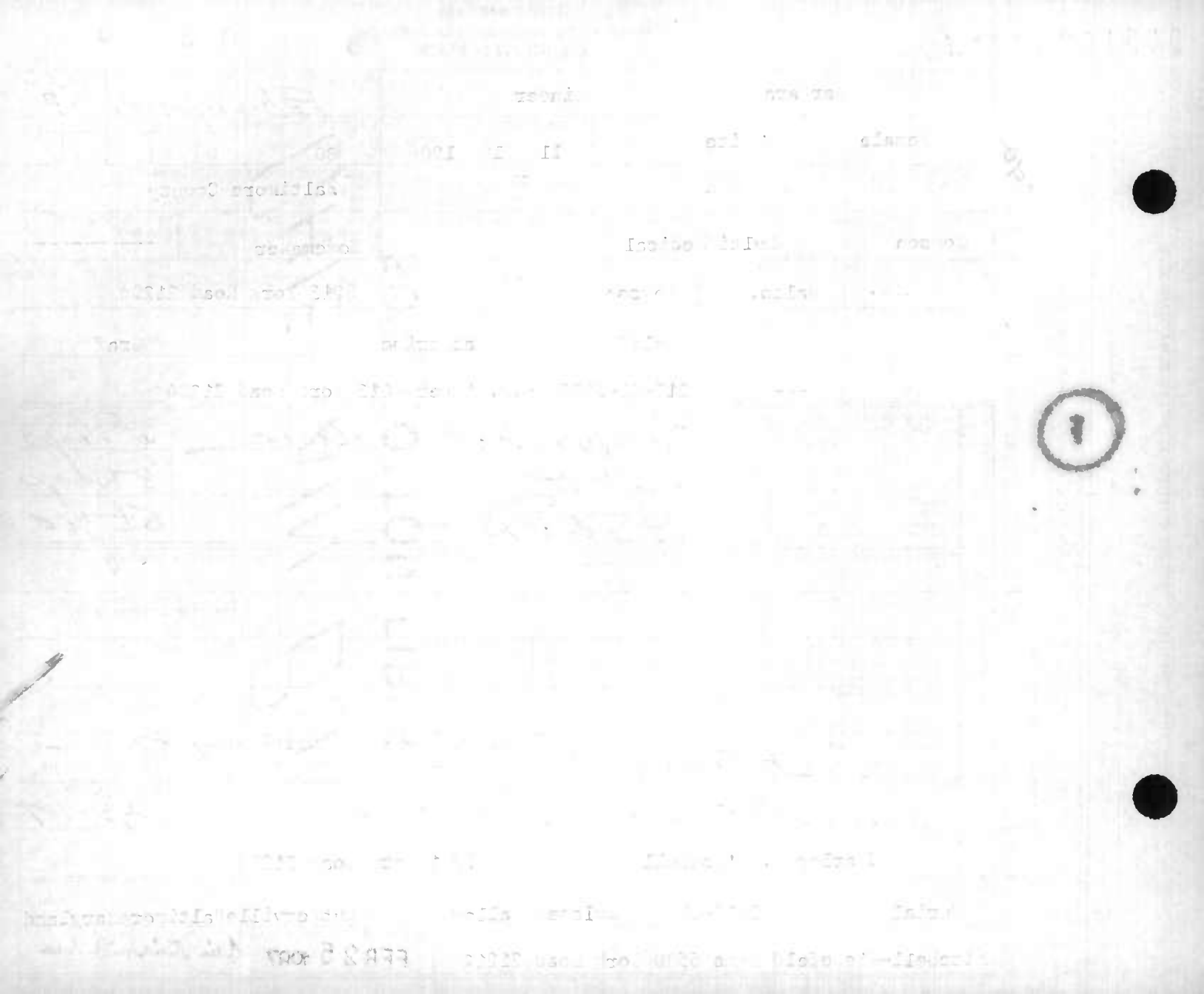
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



043900 FEB

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87

REG. NO.

03760

|   |  |   |  |   |                          |   |  |  |  |  |  |
|---|--|---|--|---|--------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN</b> <b>ALFRED</b> <b>WILSON JR.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>09</b> YEAR <b>'87</b> |   | 2b. HOUR<br><b>9:52P</b> |   |  |  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>10</b> YEAR <b>16</b>   |                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | 8. IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GMC-6701 N. CHARLES ST.</b> |  |   |                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Contracts &amp; Co-</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Westinghouse</b>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |                          | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Alfred</b> LAST <b>Wilson, Sr.</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>Ruth</b> LAST <b>Tucker</b>   |                          |   |  | 16. STREET ADDRESS / ZIP CODE<br><b>2612 Windsor Rd. Balto. Md. 21234</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW 11</b>   |                          | 17. INFORMANT<br><b>Brian Wilson</b>  |  |  |  | ADDRESS<br><b>1603 Randallwood Ct. 21084 Jarrettsville, Md.</b>                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>INTRACEREBRAL HEMORRHAGE</b>   |  |   |  |   |                          |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |   |                          |   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____  |  |   |  |   |                          |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |   |                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>       |   |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.) |   |                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>02/07</b> 19 <b>87</b> to <b>02/09</b> 19 <b>87</b> , that (I) (we) lost<br>saw the deceased alive on <b>02/09</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did not view the body after death. |  |   |  |   |                          |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>SMITH</i>  |  |   |  |   |                          | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>02/09/87</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. SMITH, M.D.</b>  |  |   |  |   |                          | 22e. ADDRESS<br><b>GMC-6701 N. CHARLES ST.</b>  |  |  |  |  |  |

MEDICAL CERTIFICATION

|  |  |                             |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b> |  | 23b. DATE<br><b>2-13-87</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Lassith N Funeral Home</b> |  |                             |  | 25a. DATE REC'D BY REGISTRAR<br><b>FEB 11 1987</b>             |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Anderson-Randall</i>                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a physician and completely filled in for the funeral director, page 3 should be detached for use on the burial transit permit. This permit is to be removed from the certificate. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (a), (b), or (c), then any injury or other significant event, the medical examiner should be notified of it.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  | REG. NO. 87 03961                 |   |
|---|--|--|---|--|-----------------------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Sarah M Wilson  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR 2-14-87 2b. HOUR 6:58 PM  |                                   |   |
| 3. SEX Female   | 4. RACE White  | 5. DATE OF BIRTH MONTH DAY YEAR 5 13 1889  |   | 6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.  |                                   | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD  |                                   |   |
| 10. CITY OR TOWN OF DEATH Towson  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. CITY OR TOWN Prince Geo. Bowie  |  |  |   | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                   | 13d. STREET ADDRESS / ZIP CODE 13019 8th St. 20715  |
| 14. FATHER'S NAME FIRST MIDDLE LAST unknown Gott  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown   |   |  |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR) No  | 16b. SOCIAL SECURITY NO. 216-01-2790   | 17. INFORMANT ADDRESS Norval Wilson Same as #13e   |   |  |                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>8583 IMMEDIATE CAUSE (a) PRE-RENAL AZOTEMIA, SEVERE<br>DUE TO, OR AS A CONSEQUENCE OF (b) DEHYDRATION, SEVERE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |  |                                   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>DIGOXIN TOXICITY  |  |  |   |  |                                   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                                   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                                   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 02-12-87 to 02-14-87, saw the deceased alive on 02-14-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |                                   |   |
| 22b. SIGNATURE Cesar G. Gamboa MD   |  | DEGREE MD  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED 2-15-87  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CESAR G. GAMBOA MD  |  | 22e. ADDRESS ST. JOSEPH HOSPITAL TOWSON  |   |  |                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  | 23b. DATE 2-18-87  | 23c. NAME OF CEMETERY OR CREMATORY Parkwood  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland  |                                   |   |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Md.  |  |  |   | 25a. DATE REC'D. BY REGISTRAR FEB 17 1987 25b. REGISTRAR'S SIGNATURE Julia Benson-Randall  |                                   |   |

CONFIDENTIAL  
TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

CONFIDENTIAL

[illegible text follows]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)GERTRUDE B.  
WINIECKISTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03968

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GERTRUDE</b>  |  | FIRST<br><b>WINIECKI</b>   |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/16/87</b>   |  | 2b. HOUR<br><b>9:30 AM</b>                                     |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 11 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MISSISSIPPI</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERIDIAN VALLEY NURSING CONVALESCENT</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b> |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>5686 UTRECHT RD 21206</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES --- BOLEWICKI</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FRANCES --- ZIEMKOWSKI</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>n/a</b>   |  | 17. INFORMANT<br><b>EDWARD W. WINIECKI</b>  |  | ADDRESS<br><b>5686 UTRECHT RD</b>   |  |  |  |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Renal failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Hypertension**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-16-87</b> to <b>2-16-87</b> , that (I) (we) last saw the deceased alive on <b>2-16-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Marion C. Kowalowski</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/16/87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. C. KOWALOWSKI</b>   |  | 22e. ADDRESS<br><b>8604 HARFORD RD</b>                                |  |  |  |  |  |

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b> |  | 23b. DATE<br><b>2/19/87</b>            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO BALTO MD</b> |  |
| 24. FUNERAL DIRECTOR<br><b>[Signature]</b>                 |  | ADDRESS<br><b>1244 Chesapeake Ave.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1987</b>         |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                    |  |

2014-10-10 20:10:10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21B shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |   |   |  |   |   |   |   |  |
|--|--|---|---|--|---|---|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>MARIE C WINTERSTEIN</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-17-87</b>                  |  |   | 2b HOUR<br><b>6:45 P.</b>   |   |   |  |
| 3 SEX<br><b>F</b>  |  | 4 RACE<br><b>W.</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 7 09</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>   |   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. Co.</b>  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON, MD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST JOSEPH HOSP.</b> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cafeteria</b>   |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Hutzlers</b>   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b>  |  | 13b COUNTY<br><b>BALTIMORE</b>  |   | 13c CITY OR TOWN   |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN R. SAVER</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FREDERICKA C. VOLKE</b>  |   | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   |   |   |   |  |
| 16b SOCIAL SECURITY NO.<br><b>219-20-6479</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>James Winterstein 4917 Linda Ave. Balto., Md.</b>   |   |  |   |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>urinary tract infection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |   |  |   |   |   |   |  |
| 19a DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21i. LOCATION<br>STREET   |   | CITY OR TOWN  |   | COUNTY STATE                                 |
| 22a I certify that (I) (this hospital) attended the deceased from <b>2/17</b> 19 <b>87</b> to <b>2/17</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2/17</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |   |   |  |   |   |   |   |  |
| 22b SIGNATURE<br><b>Natividad D. de Leon, M.D.</b>   |  |   |   |  |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |   | 22c DATE SIGNED<br><b>2/17/87</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NATIVIDAD D. DE LEON, M.D.</b>  |  |   |   |  |   | 22e ADDRESS<br><b>C/O ST. JOSEPH HOSPITAL, TOWSON, MD-21204</b>   |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b DATE<br><b>2-21-87</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>   |  |   |   |  |   | 24a DATE REC'D. BY REGISTRAR<br><b>FEB 20 1987</b>  |   | 25b REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Bidder</b>   |  |

BP

|                          |                           |
|--------------------------|---------------------------|
| 1. Name of the plant     | 2. Name of the grower     |
| 3. Name of the collector | 4. Name of the collector  |
| 5. Name of the collector | 6. Name of the collector  |
| 7. Name of the collector | 8. Name of the collector  |
| 9. Name of the collector | 10. Name of the collector |

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100. Name of the collector

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

Item # 160, Film G 626 4/1/87 ra

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8703970

REG. NO.

|  |  |   |   |   |  |  |  |  |                  |  |
|--|--|---|---|---|--|--|--|--|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Florence WOJTON  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 6, 1987  |   |  | 2b. HOUR<br>12:20 <sup>AM</sup> P  |  |  |                  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 7 1927   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |  |                  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Clerk      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Woodward & Lothrop  |                  |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br>4807 King Avenue 21236 |  |                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Cornileus Fleckenstein   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Veronica Wasil   |  |  |  |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |   | 16b. SOCIAL SECURITY NO.<br>66P-22-3708<br>801-14-2827  |   | 17. INFORMANT<br>ADDRESS<br>Stanley M. Wojton Balto., Md. 21236                          |  |  |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Ovarian Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)                  |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |   |  |  |  |  |                  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |  |  |  |                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>February 6</u> , 19 <u>87</u> , to <u>February 6</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>February 6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |  |  |  |                  |  |
| 22b. SIGNATURE<br><i>M. Thant</i>  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |  |  |  | 22c. DATE SIGNED |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. Thant, M.D.  |  |   |   |   | 22e. ADDRESS<br>9101 Franklin Square Drive, 21237  |  |  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>2-9-87   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley M.G.                                |  | 23d. LOCATION<br>CITY OR TOWN Baltimore, Maryland        |  |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lassahn Funeral Home   |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 9 1987  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John E. ...</i>         |  |                  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03971  
REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Johanna R WOLF  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 11, 1987                 |   | 2b. HOUR<br>10:30 P   |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 24, 1899   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Baltimore, Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                          |   |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Sq. Hospital |   | 12a. USUAL OCCUPATION<br>(IF OTHER THAN MOST OF WORKING LIFE)<br>Laborer |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Food Processing  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |  |   | 13b. CITY OR TOWN<br>Baltimore   | 13c. CITY OR TOWN<br>Essex  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Reif  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Stafel             |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>- 212 09 7389   |  | 17. INFORMANT<br>ADDRESS<br>Edwin P. Wolf, Son 1611 Aldeney Ave.<br>Balto., Md. 21220 |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a).<br>OVERWHELMING SEPSIS |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO OR AS A CONSEQUENCE OF<br>(b).<br>PROBABLE INTRA ABDOMINAL SOURCE OF INFECTION  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c).   |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  
CONGESTIVE HEART FAILURE

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 31, 1986, to February 11, 1987, that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on February 11, 1987, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>Hany Elnahal MD.  | DEGREE<br>M.D. - ATTENDING<br>PHYSICIAN <input type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>2/11/87  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Hany Elnahal MD.,  |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237                                      |   |

|  |                      |   |  |
|--|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial                                | 23b. DATE<br>2/14/87 | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery | 23d. LOCATION<br>BALTIMORE Co., Md. STATE            |
| 24. FUNERAL DIRECTOR<br>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave |                      | 25a. DATE REC'D. BY REGISTRAR<br>FEB 13 1987            | 25b. REGISTRAR'S SIGNATURE<br>J. A. Davidson-Landale |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This please use one carbon paper. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "true" it shows only injury, or other traumatic event, the medical examiner will be notified.

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |   |   | REG. NO. 87 03972  |  |                             |                                   |  |
|---|--|--|---|--|--|--|--|---|---|--|--|-----------------------------|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rose</b>   |  |  | FIRST <b>G</b>  |  |  | MIDDLE <b>Wolferman</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>2-15-87</b>   |  |  | 2b. HOUR <b>4:30 P.</b>     |                                   |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>WHITE</b>                       |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>5 19 1900</b> |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.                         |   |   | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN. |                                   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>County - BALTO.</b> MD. |   |  |  |                             |                                   |  |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph's Hospital</b> |  |  |  |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b> |  |                             | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO.</b>   |  |  | 13c. CITY OR TOWN <b>Balto.</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   | 13e. STREET ADDRESS / ZIP CODE <b>4900 Fort Ave. Balto. MD 21224</b>  |  |  |                             |                                   |  |
| 14. FATHER'S NAME FIRST <b>JOHN</b> MIDDLE <b>KOPPELMAN</b> LAST <b>HARTMAN</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>ELIZABETH</b> MIDDLE <b>HARTMAN</b>   |  |  |  |  |   |   |  |  |                             |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO. <b>220 12 5113</b>   |  |  | 17. INFORMANT <b>RUTH S. HAHN</b>  |  |   | ADDRESS <b>SAME AS 13e</b>  |  |  |                             |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>congestive heart failure</b>  |  |  |   |  |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                             |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |   |  |  |  |  |   |   |  |  |                             |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>atherosclerotic disease</b>   |  |  |   |  |  |  |  |   |   |  |  |                             |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |  |  |  |  |   |   |  |  |                             |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>   |  |  |   |  |  |  |  |   |   |  |  |                             |                                   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                             |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>430 P.M. 2 15 1987</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)   |  |   |   |  |  |                             |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |                             |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |   |   |  |  |                             |                                   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert B. Geller</b>   |  |  | DEGREE <b>MD</b>  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED <b>2/15/87</b>   |  |  |                             |                                   |  |
| 22d. ADDRESS <b>Robert B. Geller</b>  |  |  |   |  |  |  |  |   |   |  |  |                             |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |  | 23b. DATE <b>2-18-87</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN CEM.</b>   |  |  | 23d. LOCATION CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b>      |   |  |  |                             |                                   |  |
| 24. FUNERAL DIRECTOR <b>Hoffmann-Skarda</b>   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 18 1987</b>   |  |   | 25b. REGISTRAR'S SIGNATURE <b>John Skarda</b>   |  |  |                             |                                   |  |

BOX COLLECTION 41850

11/11/11



|    |    |    |    |    |    |    |    |    |     |
|----|----|----|----|----|----|----|----|----|-----|
| 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10  |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20  |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30  |
| 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40  |
| 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50  |
| 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60  |
| 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70  |
| 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80  |
| 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90  |
| 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. The medical examiner must be notified of one of these.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified of one of these.

043460 FEB

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR  |  | MD.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH                            |  |
| Elfriede Helga Woods  |  |  |  |  |  |   |  | Feb. 3 1987 11:04 P M                        |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR                           |  |
| Female  |  | White  |  | Mar. 10, 1929  |  | 57  |  | MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | MD.  |  |
| Vienna, Austria   |  | USA  |  |  |  | Baltimore County  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION  |  | 12b. KIND OF BUSINESS OR  |  | Self-Employ.                                 |  |
| Arbutus   |  | 5901 Oakland Road  |  |  |  | Interior Decorator  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE               |  |
| Md.   |  | Baltimore  |  | Arbutus  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 5901 Oakland Road-21227                      |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                                |  |
| Stephan VonBrett  |  | Lukes  |  | No   |  | 195-28-1143   |  | Baltimore, Md., 21218.                       |  |
|   |  |  |  |  |  |   |  | -204 E. 39th St.                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  | DUE TO, OR AS A CONSEQUENCE OF (c)                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|   |  | Cardiac Arrest   |  | Uremia   |  | Polycystic Kidney Disease   |  | 1980   |  |
|   |  |  |  |  |  |   |  | Congenital                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  | Hyperkalemia   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |
| none  |  | none   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  | 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY                         |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                      |  | CITY OR TOWN COUNTY STATE                    |  |
|   |  | P.M. 19  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 4, 1986, to Feb 3, 1987, that (I) (we) lost the deceased alive on Jan 31, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |  |  |
|   |  | Howard Belzberg  |  | M.D.   |  | 2/3/87  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY           |  |
| Howard Belzberg   |  | 22 S. Greene St. Balt. Md.   |  | Burial   |  | Feb. 5, 1987  |  | Grace Epis. Church Cem.-Elkridge, Md.        |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  | 25c. DATE REC'D. BY REGISTRAR                                       |  | 25d. REGISTRAR'S SIGNATURE                   |  |
| Sterling Funeral Estate, P. A.  |  | Feb 6 1987   |  | A. F. A.   |  | Feb 6 1987  |  | A. F. A.                                     |  |
| 736 Edmondson Ave.; Catonsville, Md. 21228  |  |  |  |  |  |   |  |  |  |

BP.

1

Stephan  
Mt.  
Austria  
Temple

USA

Van Ness  
Baltimore Avenue

Nov. 10, 1952

Woods

Feb.

1952

x  
of London road-2122

Post Office, No. 2122  
100-2-11-1-Dr.

Feb. 2, 1952 - James Earl Ray - Bridge, No.

044539 FEB 19 87

1  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 7 0 3 9 7 4  
REG. NO.

|  |   |  |   |  |   |
|--|---|--|---|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Edward Joseph WORTECK SR.            |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>February 15, 1987                     |  | 2b HOUR<br>8:00A M                        |
| 3 SEX<br>MALE  | 4 RACE<br>WHITE   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>SEPT. 30, 1918  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                       | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |   |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                      | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSP. |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALESMAN | 12b KIND OF BUSINESS OR INDUSTRY<br>PRINTING   |   |
| 13a STATE<br>Md.   |   | 13b COUNTY<br>BALTIMORE  | 13c CITY OR TOWN<br>BALTIMORE   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH WORTECK                    |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MINNIE NEULMEISTER   |   | 13e STREET ADDRESS / ZIP CODE<br>33 RIDGEMOORE Rd. 21221                                       |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES |   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII 212-01-6457   |   | 17 INFORMANT ADDRESS<br>EDWARD J. WORTECK JR. 33 RIDGEMOORE Rd. 21221                          |   |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a) Respiratory FailureAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHConditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lastDUE TO, OR AS A CONSEQUENCE OF  
(b) Pulmonary Fibrosis  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a I certify that (X) (this hospital) attended the deceased from February 7, 1987, to February 15, 1987, that (X) (we) last saw the deceased alive on February 15, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b SIGNATURE<br>Angel Triana, MD  |  | DEGREE  |  | 22c DATE SIGNED<br>2/15/87   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e ADDRESS<br>9000 Franklin Square Drive, 21237                      |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |

|  |                           |  |   |
|--|---------------------------|--|---|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION | 23b DATE<br>Feb. 17, 1987 | 23c NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT CREMATORY | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD |
| 24 FUNERAL DIRECTOR<br>NAME<br>HARTLEY MILLER            |                           | ADDRESS<br>7527 HARFORD RD                                 | 25 DATE REC'D. BY REGISTRAR<br>FEB 18 1987                |
|  |                           | 25 REGISTRAR'S SIGNATURE<br>Julia Davidson, R. 2nd         |   |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain in contact with the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8703975

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |   |  |  |   |  |  |
|--|--|---|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Dena - <del>WRIGHT</del> WRIGHT</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-16-1987</b>                   |   |   | 2b. HOUR<br><b>1245 M</b>  |  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-21-1905</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore CO. MD.</b>                     |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. CITY OR TOWN<br><b>Baltimore</b>                                     |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13. STREET ADDRESS / ZIP CODE<br><b>4026 Lewiston Ave. 21215</b>               |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Granville Dayhoff</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Blanche Elsworthy</b> |   |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>214-16-0129</b>                            |   | 17. INFORMANT<br><b>Dorothy Dawson</b>  |  |  |   | 223 <sup>ADDRESS</sup> Parkholme Circle<br>Reisterstown, Md. 21136 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis, thrombocytopenia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>C.I. BLEED. Respiratory Failure.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |   |   |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |   |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-10</b> , 19 <b>87</b> , to <b>2-16</b> , 19 <b>87</b> , that (I) (we) lost<br>saw the deceased alive on <b>2-16</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Allen J. Chiriac M.D.</b>   |  |   |   |   |   | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>2-16-87</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Allen J. Chiriac M.D.</b>  |  |   |   |   |   | 22e. ADDRESS<br><b>Eckhardt Funeral Chapel<br/>Owings Mills, Md. 21117</b>           |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Feb. 19, 1987</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Taylorsville Cem.</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Taylorsville, Carroll Md.</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Raymond Hightower</b>   |  |   |   |   |   | 25a. DATE RECEIVED BY REGISTRAR<br><b>FEB 17 1987</b>                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>John D. ...</b>  |  |  |

1



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR; PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

03976

1- FOR  
STATE  
REGISTRAR

|  |         |  |  |   |  |   |  |   |  |  |  |       |  |     |  |      |  |          |  |
|--|---------|--|--|---|--|---|--|---|--|--|--|-------|--|-----|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH                      |  | ESTI-<br>MATED                               |  | MONTH |  | DAY |  | YEAR |  | 2b. HOUR |  |
| Lewie  |         | E.   |  | Wright, Jr  |  |   |  | February 14 1987                                |  |  |  |       |  |     |  |      |  | 6P       |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS                                 |  | 7c. DATE<br>PRONOUNCED<br>DEAD               |  | MONTH |  | DAY |  | YEAR |  | 2d. HOUR |  |
| male   | black   | 1 26 36  |  | 51 YRS.   |  |   |  |   |  | February 14 1987                             |  |       |  |     |  |      |  | 6P       |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |  |  |       |  |     |  |      |  |          |  |
| Va   |         | USA  |  |   |  | Ba lto Cnty   |  |   |  |  |  |       |  |     |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |   |  |  |  |       |  |     |  |      |  |          |  |
| Baltu  |         | 6666 Collinsdale Road  |  | Disabled  |  |   |  |   |  |  |  |       |  |     |  |      |  |          |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |         | 13b. STATE   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                             |  |  |  |       |  |     |  |      |  |          |  |
| Md   |         | Baltu  |  | Baltu   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 6666 Collinsdale Road                           |  |  |  |       |  |     |  |      |  |          |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |   |  |  |  |       |  |     |  |      |  |          |  |
| David  |         | Helen  |  |   |  |   |  |   |  |  |  |       |  |     |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |  |  |       |  |     |  |      |  |          |  |
| NO   |         | 219-32-2520  |  | Elvira Wright   |  | 6666 Collinsdale Road   |  |   |  |  |  |       |  |     |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:   |         | IMMEDIATE CAUSE (a)  |  | (b)   |  | (c)   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |  |       |  |     |  |      |  |          |  |
| Cordic Arrest  |         | Kidney Failure   |  | ASCD  |  |   |  | Sudden  |  |  |  |       |  |     |  |      |  |          |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.   |         |  |  |   |  |   |  | 2+ yrs  |  |  |  |       |  |     |  |      |  |          |  |
|  |         |  |  |   |  |   |  | 2+ yrs  |  |  |  |       |  |     |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.                                |         |  |  |   |  |   |  |   |  |  |  |       |  |     |  |      |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |   |  |   |  |  |  |       |  |     |  |      |  |          |  |
|  |         |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |  |  |       |  |     |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |  |  |       |  |     |  |      |  |          |  |
|  |         | P.M. 19  |  |   |  |   |  |   |  |  |  |       |  |     |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY  |  | STATE  |  |       |  |     |  |      |  |          |  |
|  |         |  |  |   |  |   |  |   |  |  |  |       |  |     |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an  |         | Autopsy <input type="checkbox"/>   |  | Inspection <input type="checkbox"/>   |  | Inquiry <input checked="" type="checkbox"/>                         |  | and in my opinion                               |  |  |  |       |  |     |  |      |  |          |  |
| death resulted from:   |         | Natural causes <input checked="" type="checkbox"/>   |  | Accident <input type="checkbox"/>   |  | Suicide <input type="checkbox"/>                                    |  | Homicide <input type="checkbox"/>               |  | Undetermined manner <input type="checkbox"/> |  |       |  |     |  |      |  |          |  |
| ACTUAL<br>SIGNATURE  |         | TITLE (SPECIFY)  |  | DATE<br>SIGNED  |  |   |  |   |  |  |  |       |  |     |  |      |  |          |  |
| Charles F. O'Connell   |         | M.D. Deputy  |  | 3/14/87   |  |   |  |   |  |  |  |       |  |     |  |      |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |  |   |  |   |  |   |  |  |  |       |  |     |  |      |  |          |  |
|  |         |  |  |   |  |   |  |   |  |  |  |       |  |     |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>(CITY OR TOWN)                                     |  | COUNTY  |  | STATE  |  |       |  |     |  |      |  |          |  |
| Burial   |         | 2-20-87  |  | King Memorial   |  | Randallstown  |  |   |  | Md   |  |       |  |     |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME   |         | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |       |  |     |  |      |  |          |  |
| Wm. C. March F.H.  |         | 1101 E. North Ave  |  | FEB 19 1987   |  | Julia Anderson-Randall  |  |   |  |  |  |       |  |     |  |      |  |          |  |

1901 3 1901

1

1901 3 1901



Item #8 6627 5-35-87 25

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03977

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William Henry WUNDER Jr  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 23 87 |   |  | 2b. HOUR<br>6:30 A  |  |
| 1. SEX<br>Male  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>SEPT-18, 1927   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSDALE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mach.   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>LUTH. HOSP.  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Maryland |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET ADDRESS / ZIP CODE<br>342 SASSAFRAS ROAD 21221  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William H. WUNDER SR.   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna E. MOLTGREES  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-22-2586  |  | 17. INFORMANT<br>ADDRESS<br>FAMILY RECORDS  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory Arrest

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHConditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

Pulmonary Edema

DUE TO, OR AS A CONSEQUENCE OF

Metastatic Lung Cancer

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 21g. I certify that (I) (this hospital) attended the deceased from Feb 12 1987 to Feb 23 1987, that (I) saw the deceased alive on Feb 23 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22a. SIGNATURE<br>Lisa Beasley  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2/23/87   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lisa Beasley, MD   |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Drive 21237   |  |   |  |

|   |  |                           |  |   |  |  |  |
|---|--|---------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION               |  | 23b. DATE<br>Feb 26, 1987 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>EVANS CHAPL OF MEMORIES HARFORD |  |                           |  | 25a. DATE REC'D. BY REGISTRAR                     |  | 25b. REGISTRAR'S SIGNATURE<br>John S. Parker                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FEB 26 1987



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

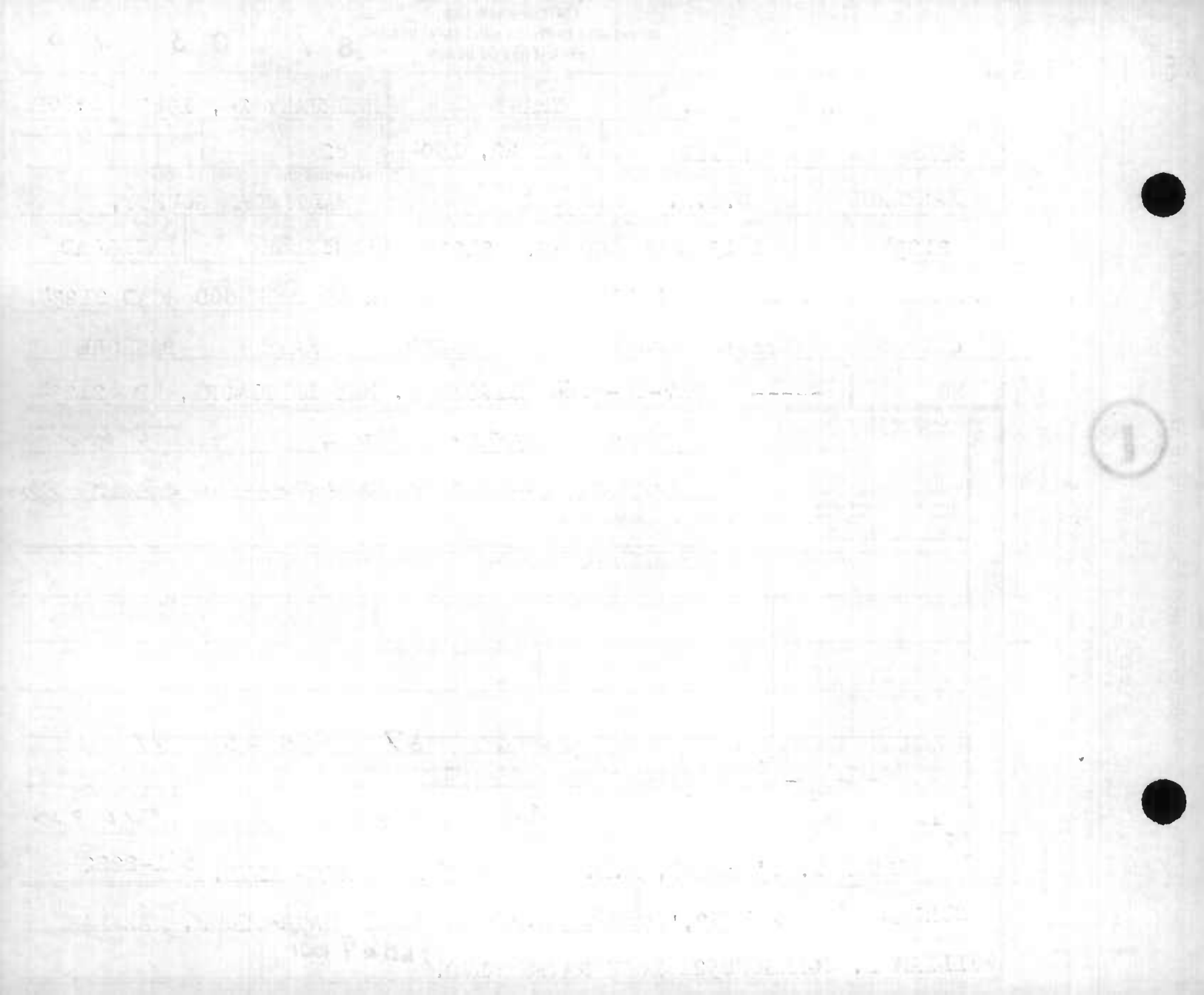
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |   |   |  | 87 03978   |  |
|--|--|---|--|---|---|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |   |   |   |   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARRY W. YEAGY</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 26, 1987</b>   |   |   | 2b. HOUR<br><b>1:00 P.M.</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 22, 1904</b>  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>82</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>                  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>                            |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>21234</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1815 CROMWOOD RD. 21234</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ENGINEER</b>             |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>                      |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>21234</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1815 CROMWOOD ROAD 21234</b>         |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE COLLINS YEAGY</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARTHA KATE BASHORE</b>   |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>717-07-8864</b>   |  | 17. INFORMANT ADDRESS<br><b>WILLIAM F. MAY BALTIMORE, MD 21234</b>  |   |   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>5 MIN</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 MIN</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 6</b> 19 <b>87</b> to <b>FEB 26</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>FEB 13</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) not view the body after death.   |  |   |  |   |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Samuel I. O'Mansky</b>  |  |   |  |   | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |   |  | 22c. DATE SIGNED<br><b>FEB 27</b>                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SAMUEL I. O'MANSKY, M.D.</b>   |  |   |  |   | 22e. ADDRESS<br><b>8405 LOCH AVEN BLVD. 661-2222</b>  |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>MARCH 3, '87</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>REST HAVEN CEMETERY</b>  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>HAGERSTOWN, MARYLAND</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM E. JOHNSON</b>  |  |   |  |   | ADDRESS<br><b>8521 LOCH RAVEN BLVD.</b>   |   |   | 25a. DATE RECEIVED BY REGISTRAR<br><b>FEB 27 1987</b>                     |  | 25b. REGISTRAR'S SIGNATURE                                   |  |

BP



|  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                              |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|------------------------------|--|--|--|--|
| 045341 FEB 26 1987   |  |  |  |  |   |  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | 87 03979<br>REG. NO.                                    |  |  |  |  |                              |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles Yeoman  |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 16 87  |  |  |  |  |  |  |  |  |  | 2b. HOUR<br>9:45 P.M.                                   |  |  |  |  |                              |  |  |  |  |
| 3. SEX<br>M  |  |  |  |  | 4. RACE<br>B  |  |  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 15 08   |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                          |  |  |  |  | IF UNDER 24 HRS<br>HOURS MIN |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                 |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |  |  |  |  |   |  |  |  |  |                              |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County Gen. Hosp |  |  |  |  |   |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>farmer             |  |  |  |  |                              |  |  |  |  |
| 13a. STATE<br>MD   |  |  |  |  | 13b. COUNTY<br>Baltimore  |  |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  |  |  | 13e. STREET ADDRESS / ZIP CODE<br>3108 Croydon Rd 21207 |  |  |  |  |                              |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alfred Jones   |  |  |  |  |   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Georganna Yeoman   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                              |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  |  |  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>212-32-3305   |  |  |  |  | 17. INFORMANT<br>ADDRESS<br>Thelma Robinson 3408 Croydon Rd. Baltimore, Md  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                              |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF (b) Extra-cerebral Bleeding<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) Dissecting Aortic Aneurysm<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Prostatic Carcinoma |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                              |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |   |  |  |  |  |                              |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                              |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                              |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 1/24 1987 to 2/16 1987, that (we) lost<br>saw the deceased alive on 2/16 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (the) (e) (did) (did not) view the body after death.  |  |  |  |  |   |  |  |  |  | 22b. SIGNATURE<br>Robert L. Moss MD<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>2/16/87                             |  |  |  |  |                              |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert L. Moss  |  |  |  |  | 22e. ADDRESS<br>Baltimore County Gen. Hosp Randallstown   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                              |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial   |  |  |  |  | 23b. DATE<br>2-21-87  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Balto. MD.   |  |  |  |  |   |  |  |  |  |                              |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Arnold W. Beard Havre de Grace, Md.  |  |  |  |  |   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 24 1987  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>John Robinson-Lindner     |  |  |  |  |                              |  |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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DHMH - 16 60M 7/B4 (VRA 15, 4)

100% COTTON FIBRE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |   |   |             |   |  |  |   |   |
|---|---|---|-------------|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST   | MIDDLE      | LAST  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |   |
| Edna Bertha YOUNG   |   |   |             |   | February 3, 1987   |  | 10:25p <sub>M</sub>   |   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |             | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS             |   | IF UNDER 24 HRS.<br>HOURS MIN.                  |
| Female  | White   | 7-27-1900   |             | 86 YRS.   |  |  |   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |             | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |   |   |
| Md.   | U.S.A.  |   |             | Baltimore County MD.  |  |  |   |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY          |   |   |
| Rossville   | Franklin Square Hospital  |   |             | Homemaker   |  |  |   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   | 13b. STATE  | 13c. COUNTY | 13d. CITY OR TOWN   | 13e. STREET ADDRESS / ZIP CODE   |  |   |   |
| Md.   |   | Balto.  | Balto.      | Balto.  | 8806 Baker Ave. 21234  |  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |             | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  |   |   |
| Jacob Betz  |   | Marie Harsch  |             | No  |  |  |   |   |
| 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT   |             | ADDRESS   |  |  |   |   |
| 213-74-5441   |   | Shirley DeShong   |             | White Hall, Md.<br>4207 Norrisville Rd.   |  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest; Ruptured Abdominal Aortic Aneurym</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |   |   |             |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |             |   |  |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |             |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>February 2, 1987</u> to <u>February 3, 1987</u> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <u>February 3, 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |   |   |             |   |  |  |   |   |
| 22b. SIGNATURE<br><u>Gregory Ross</u>   |   | DEGREE<br><u>M.D.</u>   |             | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>2/3/87</u>          |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gregory Ross, M.D.   |   | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |             |   |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE   |             | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |   |
| Burial  |   | 2-7-87  |             | Parkwood  |  | Balto., Md.                                |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc., 5305 Harford Rd.   |   |   |             | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                 |   |   |
|   |   |   |             | FEB 4 1987  |  |  |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 87 03981

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>PETER YOVANOVICH   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 18, 1987                   |  | 2b. HOUR<br>9:00 AM  |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JANUARY 28, 1906  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>YUGOSLAVIA  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VA MEDICAL CENTER |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Barber |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-employed   |
| 13a. STATE<br>MARYLAND  |  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>BALTIMORE   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN YOVANOVICH   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MINNIE Mileva Zivkovich   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>WWII<br>212 18 5208   |  | 17. INFORMANT<br>Mira Lalich ADDRESS 2012 W Rogers Av<br><del>VA MEDICAL CENTER, FORT HOWARD, MD 21209</del> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>ADVANCED CHRONIC OBSTRUCTIVE PULMONARY DISEASE  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22. I certify that (I) (this hospital) attended the deceased from JUNE 24, 19 85, to FEBRUARY 18, 19 87, that (I) (we) lost saw the deceased alive on FEBRUARY 18, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |   |  |  |  |
| 27b. SIGNATURE<br>  |  |   |  | 27c. DATE SIGNED<br>2-18-87  |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C.V.J. VERGHESE, M.D.  |  |   |  | 27e. ADDRESS<br>VA MEDICAL CENTER, FORT HOWARD, MD 21052   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>02/23/87   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Md 21229   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Walters Funeral Home/Pratt & Stricker Streets Balto Md 21223  |  |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE<br>   |

BP \_\_\_\_\_

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3

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

| SECTION   |  | TOWNSHIP |  | RANGE |  | COUNTY |  | STATE |  |
|---|--|----------|--|-------|--|--------|--|-------|--|
| 34  |  | 34       |  | 34    |  | 34     |  | 34    |  |
| [Faint, illegible text and markings throughout the form body] |  |          |  |       |  |        |  |       |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please detach page 4. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>JAMES BARTON ZABIN  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 5, 1987 |  |  | 2b. HOUR<br>4 AM  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 5 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto. County  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2915 Woodvalley Drive |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Executive   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Advertising              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MD  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13d. STREET ADDRESS / ZIP CODE<br>2915 Woodvalley Dr., 21208   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Barton Zabin   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Stella Rothstein  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>087 10 9889   |  | 17. INFORMANT ADDRESS<br>Mrs. Laurie Zabin, Same  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ponguive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis Generalized</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Ascites 3 due to above</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/5</u> 19 <u>87</u> to <u>2/5</u> 19 <u>87</u> , that (we) last saw the deceased alive on <u>2/5</u> 19 <u>87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Jerome J. Collier MD</u>   |  |   |  | 22c. DEGREE<br>MD   |  |  |  | 22d. DATE SIGNED<br>2/5/87                                    |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JEROME J. Collier MD   |  |   |  | 22f. ADDRESS<br>1777 Reisterstown Rd  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>2/6/87   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto., MD  |  | 23e. DATE REC'D. BY REGISTRAR<br>FEB 6 1987                   |  |
| 24. FUNERAL DIRECTOR NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212   |  |   |  | 25. REGISTRAR'S SIGNATURE<br>Julia Dickinson-Randall  |  |  |  |   |  |

February 2, 1977

County of Albany

Executive

State of New York

Prothonotary

one

(copy for Court Clerk)

RECEIVED

Administrative Services

Routes & Auto Shop

(copy for Court Clerk)

2/2/77

2/2/77

2/2/77

2/2/77

2/2/77

2/2/77

2/2/77

2/2/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 03983  
REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ANNA ZANELLA  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 4, 1987  |  | 2b. HOUR<br>12:03a M  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 10, 1980  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>96 YRS.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Italy   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baynesville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Valley View Nursing Home |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Lutherville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown Nano  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose Unknown   |  | 13e. STREET ADDRESS / ZIP CODE<br>201 E. Seminary Ave. 21093  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>153-42-3240  |  | 17. INFORMANT ADDRESS<br>Foster J. Zanello, Jr. - same as #13e  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Dyspnea</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Organic Brain Sct</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>80</u> to <u>2/4/87</u> , that (I) (we) lost<br>saw the deceased alive on <u>1/30/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did not view the body after death.   |  |   |  |   |  |   |  |
| 27b. SIGNATURE<br><u>Dr. Vuong Nguyen</u>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 27c. DATE SIGNED<br><u>2/4/87</u>   |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Vuong Nguyen   |  | 27e. ADDRESS<br>Valley View Nursing Home-Emge Rd. 21234   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>2-7-87   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lady of Mt. Carmel  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hazelton, Luzerne Penna.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.  |  | ADDRESS<br>1050 York Rd.<br>Towson, Md. 21204   |  | 25a. DATE REC'D. BY REGISTRAR<br>9 1987   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please advise the coroner's office. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 showing any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |   |  |  |
|---|--|--|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Francis Xayier Zell</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 10 87</b>   |  | 2b. HOUR<br><b>8:50 AM</b>  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>July 2 1916</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS                                     |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                         |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Milkman</b>      |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sealtest Dairy</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>                                  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13d. STREET ADDRESS / ZIP CODE<br><b>505 Nassau Avenue 21208</b>              |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Harry Thomas Zell</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Michael</b>  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>217-01-8551</b>                         |   | 17. INFORMATION ADDRESS<br><b>Mr. Vincent W. Michael 21215</b><br><b>3310 Parkington Avenue Baltimore Maryland</b>                                   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Electro mechanical Dissociation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Artery Disease</b>   |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>Diabetes Mellitus</b>  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/9</b> , 19 <b>87</b> , to <b>2/10</b> , 19 <b>87</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/10</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Allen J. Churchill M.D.</b>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>2-10-87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Allen J. Churchill M.D.</b>   |  |  |  |   | 22e. ADDRESS<br><b>Baltimore County General Hosp</b>   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>2/13/87</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville Baltimore MD.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Loring Byers Funeral Directors, Inc</b><br>ADDRESS <b>8728 Liberty Road Randallstown, Maryland 21133</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 11 1987</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the body be retained by the hospital or attending physician.

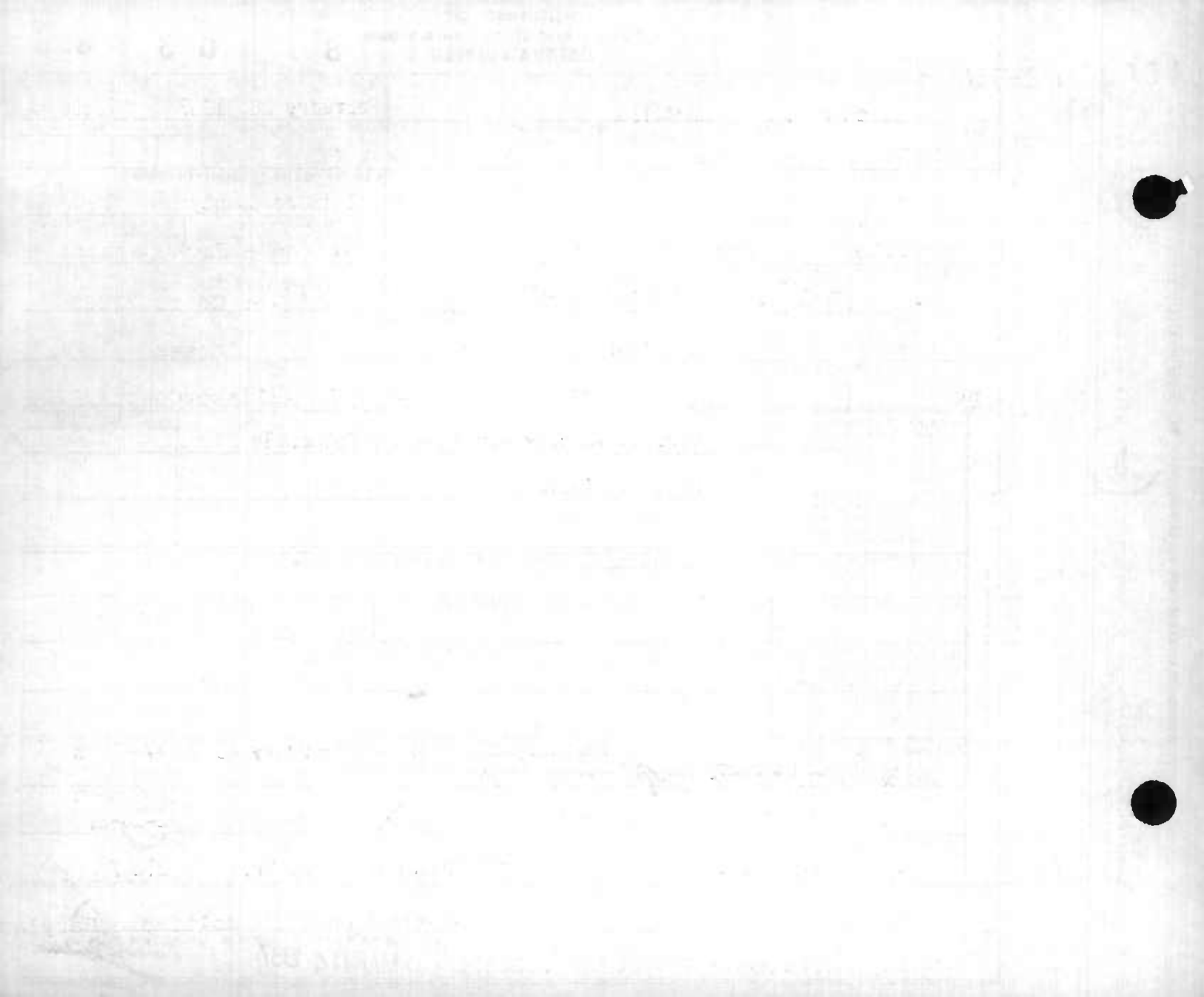
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 03985  
REG. NO.1- FOR  
STATE  
REGISTRAR

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Peter C. ZEMAITIS  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 28, 1987                           |  | 2b. HOUR<br>3:53 pm  |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb 19 1921   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>New York   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                        |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired - Jack |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Operator  |
| 13a. STATE<br>Md.   |   |   | 13b. CITY OR TOWN<br>Balto.  | 13c. CITY OR TOWN<br>Middle River  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Anthony Zemaitis  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Moses                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br>no  |   | 16b. SOCIAL SECURITY NO.<br>166-16-4366   | 17. INFORMANT<br>ADDRESS<br>Frances Zemaitis 4Blinker Court 21220                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary Arrest - Cor Pulmonale<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (b) Pneumoconiosis<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 28, 1987, to February 28, 1987, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 28, 1987, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death. |   |   |  |  |  |
| 22b. SIGNATURE<br><i>J. Connelly</i>  |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>2-28-87  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Connelly, M.D.  |   | 22e. ADDRESS<br>9000 Franklin Square Dr. 21237  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>3/4/87   | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Jesus   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dundalk Baltimore Maryland             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Connelly Funeral Home   |   | ADDRESS<br>300 Mace Ave. 21221  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 04 1987   | 25b. REGISTRAR'S SIGNATURE<br><i>Julius Anderson-Randall</i>   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove car-body papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 03986  
REG. NO.

|  |  |   |  |                        |  |
|--|--|---|--|------------------------|--|
| 1. STATE REGISTRAR   |  | 2a. DATE OF DEATH   |  | 2b. HOUR               |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST   |  | MONTH DAY YEAR         |  |
| Mrs. Grace L. Zimmerman  |  |   |  | February 9 1987 645 PM |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                | IF UNDER 1 YEAR        |  |
| Female   | Caucasian  | August 18 1909  | 77   | MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |                        |  |
| Maryland   | U.S.A.   |   | Baltimore County   |                        |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION                | 12a. USUAL OCCUPATION (IF MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY                              |                        |  |
| Randallstown   | Baltimore County General Hospital                                      | Homemaker   |  |                        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   | 13b. CITY OR TOWN  | 13c. INSIDE CITY LIMITS?  | 13d. STREET ADDRESS  |                        | 13e. ZIP CODE                                |
| Maryland   | Carroll  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 5718 Oakland Road  |                        | 21784  |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME   | 16. SOCIAL SECURITY NO.   |  |                        |  |
| Clarence Adolphus Multineaux   | Bertha May Hennick   | 212-52-5809   |  |                        |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)   | 17b. ADDRESS   | 17c. CITY OR TOWN   |  |                        |  |
| No   | 5718 Oakland Road  | Sykesville Maryland   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |                        |  |
| IMMEDIATE CAUSE (a) Acute Renal failure  |  |   |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |                        |  |
| (b) Sepsis   |  |   |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |                        |  |
| (c) Chronic Renal failure & Bacteremia   |  |   |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |   |  |                        |  |
| OGI bleeding @ IN A VITATION   |  |   |  |                        |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                        |  |
|  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 01-6-1987, to 2-9-1987, that (I) (we) last saw the deceased alive on 2-9-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |                        |  |
| 22b. SIGNATURE   | DEGREE   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED       |  |
|  |  |   |  | 2-9-87                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  | 22e. ADDRESS   |   |  |                        |  |
| M. ENOUR   |  |   |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION  |                        |  |
| Burial   | 2-13-87  | Mt. Olive Church Cem  | CITY OR TOWN COUNTY STATE                                      |                        |  |
|  |  |   | Randallstown Baltimore MD                                      |                        |  |
| 24. FUNERAL DIRECTOR   | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                     |                        |  |
| Loring Byers Funeral Directors, Inc  | FEB 11 1987  |   | Julia Gordon-Rodgers   |                        |  |
| 8728 Liberty Rd. Randallstown, MD 21133  |  |   |  |                        |  |

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DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with you 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |  |
|---|--|--|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Clarence Dudley Zenter  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 12 87<br>2b. HOUR<br>1:15 P.M.          |   |  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 13 1903   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83<br>YRS                           |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridian Nursing Home |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Freight Adj. |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Railroad  |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Howard  |  | 13c. CITY OR TOWN<br>Ellicott City  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>8662 Frederick Rd. 21043   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick A. Zenter   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Catherine Burriss   |  |   |  | ADDRESS<br>4933 Montgomery Rd. 21043   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>705-05-7252   |  | 17. INFORMANT<br>Maynard Zenter Sr.   |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CH. with M.H. stroke</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |  |  |   |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE                                       |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-11-86</u> , 19____, to <u>2-12-87</u> , 19____, that (I) (we) last saw the deceased alive on <u>2-11-87</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><u>George D. N. 90V</u>   |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br><u>2/13/87</u>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE D N 90V   |  |  |  | 22e. ADDRESS<br>3350 Wilkins Dr. Belts  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>2-14-87   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rockville Union Cem.  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Rockville Montgomery Md. |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Black Funeral Home  |  |  |  | ADDRESS<br>Box 268 Ellicott City, Md. 21043   |  | 25. DATE REC'D. BY REGISTRAR<br>FEB 20 1987   |  | 26. REGISTRAR'S SIGNATURE<br>Julia Gordon-Randall  |  |  |

